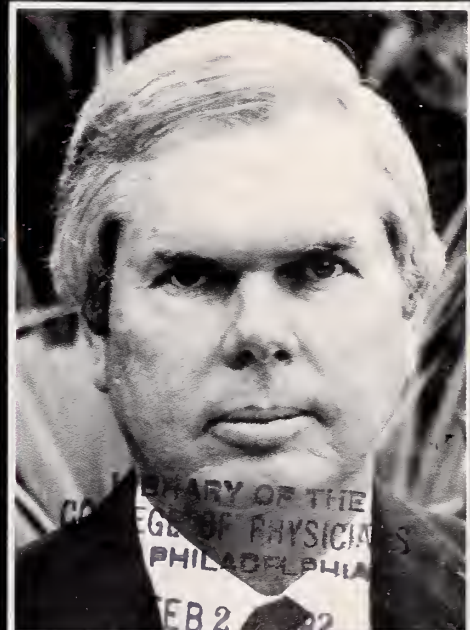
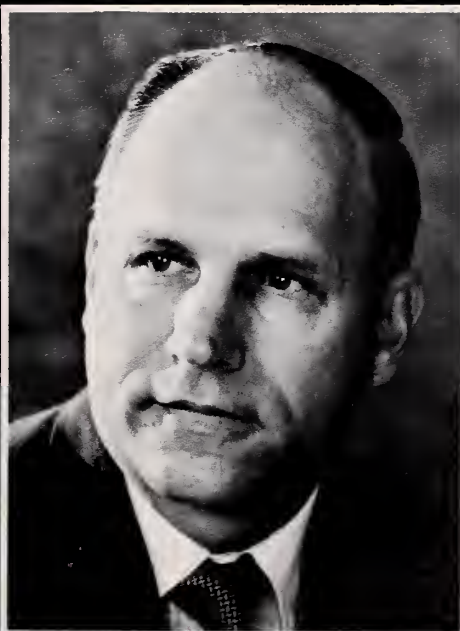
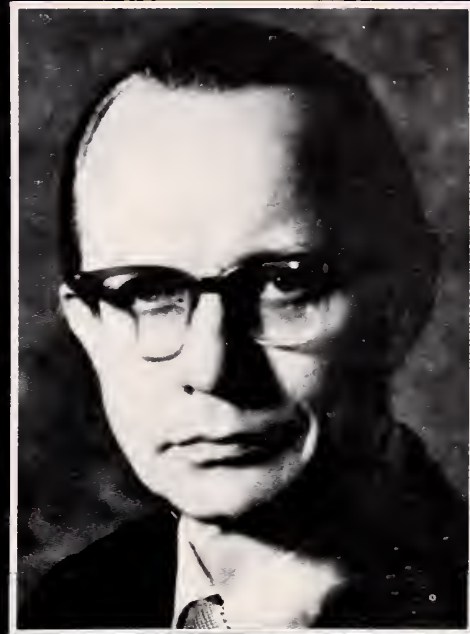


THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

JANUARY 1982 • VOL 69 • NO. 1



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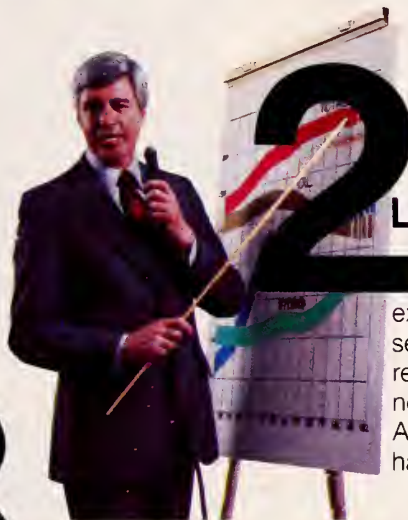
Four practical reasons to prescribe **Ativan[®]** **for** (lorazepam) **Anxiety***



1

No interaction with more than 300 drugs[†]

In clinical studies, Ativan was given concomitantly with hundreds of medications, including gastrointestinal and cardiovascular, with no reported interactions. Whereas the interaction of diazepam and cimetidine has been shown to cause increased sedation in patients taking both drugs, the clearance of Ativan is not delayed by Tagamet.[‡]



2





Lets most patients stay active

Long-acting benzodiazepines have long-acting metabolites with activity which can produce excessive accumulation that may lead to unwanted sedation. Ativan[®] has no active metabolites, reaches steady state in 2 to 3 days and usually does not cause oversedation. Also, the shorter half-life of Ativan is consistent with b.i.d. dosage, so drug hangover is seldom a problem the next morning.



3

Not appreciably affected by aging

Unlike the long-acting benzodiazepines—diazepam , chlordiazepoxide , clorazepate  and prazepam —the metabolism and clearance of Ativan are not appreciably affected by the aging process.



4

Not significantly affected by liver dysfunction

Ativan[®] is metabolized in one simple step to an inactive glucuronide; its absorption and excretion are not significantly altered by cirrhosis or hepatitis. By contrast, the metabolism of diazepam and chlordiazepoxide has been reported to be significantly altered in patients with liver dysfunction.

*Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic.

†All benzodiazepines, however, produce additive effects when given with CNS depressants, such as barbiturates or alcohol.

‡Tagamet (cimetidine) is a registered trademark of Smith Kline & French Laboratories, Division of SmithKline Corporation.

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See important information on following page.

Wyeth Laboratories
Philadelphia, PA 19101



Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any anxiolytic agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chloridiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan[®]
for (lorazepam)
Anxiety

Dosage: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

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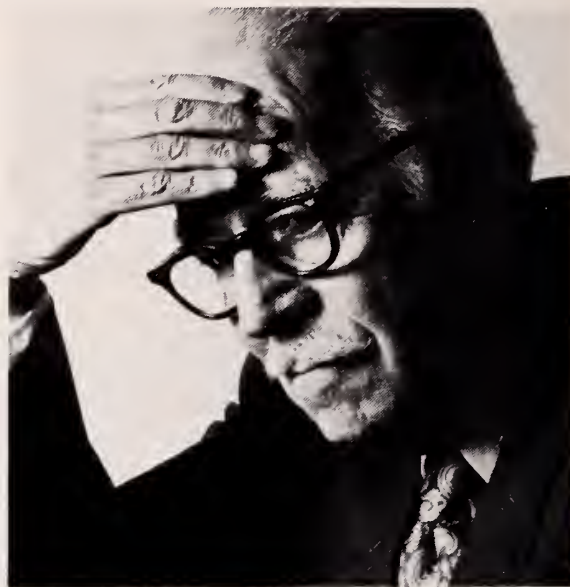
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DOSAGE: One ISO-BID capsule every 12 hours on an empty stomach according to need, for continuous 24-hour therapy. Some patients may require higher dosage levels. In these patients, dosage should be titrated, and they may require two ISO-BID capsules b.i.d. Not intended for sublingual use. Consult product brochure before prescribing.

THERAPEUTIC FOOTNOTE: IN TREATING ANGINA ... FAILURES MAY RESULT FROM INADEQUATE DOSAGE. Reports in the literature indicate the usefulness of higher dosage levels of isosorbide dinitrate.¹⁻³

INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: For the relief of angina pectoris (pain of coronary artery disease). ISO-BID is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris. Final classification of the less-than-effective indication requires further investigation.

CONTRAINDICATION: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Use with caution in patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness

and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.

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President's Page

The 1982 Session of the Florida Legislature

The Florida Legislature will convene its regular annual session on January 18, 1982. This is approximately three months earlier than the usual April opening. The principal reason for this early convening of the Legislature is the requirement by the Constitution of Florida for the Florida Legislature to apportion itself following each decennial census of the United States.

As a result of this constitutional requirement, there will be a geographical rearrangement of the districts of each House and Senate seat. In all probability, this will be followed by elections for each seat in the Legislature, although there is some divergence of opinion as to whether or not all seats in the Florida Senate will necessarily be subjected to the election process in 1982.

Another important factor related to the early legislative session is the four new seats Florida will have in the United States House of Representatives as a result of the increase in population during the ten years prior to the 1980 census. This will make it necessary for all congressional seats to be redistricted.

These two important apportionment actions will be the responsibility of the Florida Legislature, subject to the overview of the Florida Supreme Court for the Florida Legislature and the United States Department of Justice for the Congressional Districts. The Court and the Department have the power to accept or reject the proposed apportionment plans. If the Legislature is unable to prepare a plan for apportionment which is satisfactory to the Court and/or the Department, it will be the responsibility of those bodies to make the final determination relative to apportionment. In any event all of this must be accomplished by the early summer of 1982 in order to allow time for the elections to the Legislature and to the Congress which are scheduled for the fall of 1982.

The time and effort which will be expended on apportionment would be enough to keep the Legislature occupied for virtually a full legislative session without any other items for their consideration but many additional matters of importance must be addressed by the Legislature in the 1982 session. For example, the Legislature will have to establish the new budget for the State of Florida, an item which will undoubtedly require considerable work before the House and Senate come to a final agreement.

In addition to the budget and many other important matters, of particular significance to the medical profession is the legislative consideration of the Sunset Review Law as it applies to the Florida Insurance Code and to the Hospital Licensure Law. The Legislature must decide to continue these laws as they are now written or modify them or they will be repealed. It is obvious that both of these laws have major impact on the individual practitioner. There are multiple other items of concern to the medical profession. Several of these are related to the efforts of various inadequately qualified groups attempting to practice medicine.

In the past, many physicians have felt that involvement in legislative activities was somehow beneath the dignity of the profession. Nothing could be further from the truth. It is absolutely essential for the medical profession to become aware of, and involved in, the legislative process. Lobbying is the right of every American citizen and should not be ignored. It must never be forgotten that the Legislature has literally the power of life and death over the medical profession.

For many years the FMA has had a strong and effective program for legislative activities. The high quality of the FMA program is greatly respected by most

members of the Legislature. The overriding consideration of the FMA legislative effort is the protection and enhancement of the health of the people of the State of Florida. For over 100 years the FMA has been engaged in a continuing effort to improve health standards for all of the people of Florida. The efforts of the FMA in the Legislature began back in the 19th century when a State Board of Health was established primarily due to the efforts of the FMA.

The specific problems concerning health legislation vary from year to year but the basic concept is the same — the protection of the health of the people. The essential feature in providing good health care for the people of Florida is the recognition that medicine must be allowed to provide its services with a minimum of governmental intervention at all levels. There must also be a continuing effort to avoid legislative actions which would erode the practice of medicine and allow unqualified individuals to practice substandard medicine on the people of Florida.

The members of the FMA must recognize the need to become involved in the legislative process and to become personally acquainted with the legislators representing their districts. By being knowledgeable of the subjects of particular concern to medicine, and by being friendly and cooperative with the legislators at the local level, doctors will have a much greater ability to gain the attention of the legislators during the legislative session. It is important for physicians to be objective and factual in discussing legislative matters with their senators and representatives.

Doctors becoming involved in the legislative process should always coordinate their efforts with the FMA to make certain that the medical profession speaks with a single voice. Information concerning legislative topics of

particular interest to individual physicians can be obtained through the FMA Tallahassee office or through many of the county medical society offices. The FMA will attempt to provide accurate information as promptly as possible.

An important caution to individuals who are interested in becoming involved in the legislative process is that they become informed about the subject before discussing it. It is essential for interested doctors not to attempt to answer questions or discuss matters about which they are not familiar. Information concerning the 1982 FMA legislative priorities has already been distributed to the county medical societies and to many individual physicians. Copies of this material are available on request by any FMA member.

It should also be pointed out that physicians should recognize the importance of the individuals on the staffs of the various representatives and senators. Many times the aides can be reached more readily than the legislator. At such times it is important for the person trying to pass on the information to the legislator to be able to relate the facts to the aide in such a way as to assure proper information being transmitted to the legislator. Wherever possible it is highly desirable for the physician to become personally acquainted with the legislator's staff before the session begins.

The 1982 session of the Legislature will have a major impact on the practice of medicine in the State of Florida. It is vital for every physician to be aware of this impact and to take appropriate steps at the local level to become involved in the legislative process. All efforts should be coordinated with the various county medical societies and the FMA. By working together medical doctors can have a significant influence in assisting the Legislature to protect and improve the health of the people of Florida.

Sanford A. Pullen, M.D.



Professional Liability Legal Update

Patient's Contributory or Comparative Negligence

A recent appellate decision dealt with the question of whether a patient's contributory negligence can be asserted as a full or partial defense to a malpractice action brought by that patient. The case in question involved a patient, who upon arrival at a hospital emergency room, was examined by the defendant physician and determined to be suffering from an overdose of Valium and Darvocet taken in conjunction with a large amount of beer in an apparent suicide attempt.

The examining physician directed that the patient be orally given an ounce and one-half of Ipecac. The Ipecac was administered at approximately 8:00 p.m. by a registered nurse employed by the hospital. When she gave the Ipecac to the patient, she advised him and his wife, who was present in the cubicle, that she wanted him to drink water. She further instructed the wife to make the patient drink the water. Both his wife and a friend were unable to induce the patient to drink any water. The patient's friend eventually left the emergency room, but before doing so advised the nurse that the patient was not drinking water. He also noted that, when he left the emergency room, the patient appeared to be unconscious.

Approximately 38 minutes later, the nurse walked by the patient's cubicle in the emergency room and noted that his color had changed. She immediately reported to the nurse's station that someone needed to check the patient for his color "didn't look right." When the nurse advised the nursing station that the patient needed to be checked, the examining physician, a second registered nurse and a unit secretary were in the station. The unit secretary then left the station on an errand. Upon returning, she passed by the patient's cubicle and noted that his color was much darker than when he first came in. She too advised the examining physician of the color

change. He in turn told her to request the second registered nurse to do a gastric lavage. She noted that he was less responsive and variously described his color as being "dusky or gray" and "very dusky, very dark." Upon placing her hand upon his chest and stomach, she found that there was no movement. She lowered his bed, established an airway, and immediately went back to the nurse's station to call a Code 3. The deceased was resuscitated and moved to the Intensive Care Unit of the Hospital. However, he never regained consciousness and died 27 days later.

The deceased's wife, on behalf of the Estate, brought a malpractice suit against the physician and the hospital. In the presentation of its case, the Estate called as an expert witness an emergency room doctor who testified that he believed that the patient's death was due to brain damage caused by lack of oxygen. He also testified that in his opinion the care received by the patient deviated from the standard of practice in the community because a qualified nurse saw a color change in a patient that had taken an overdose and did not immediately check to see if he required supportive care. The expert witness further opined that, had the deceased been checked immediately and supportive care been given immediately upon the cyanosis being observed, the deceased would be alive today. The defense called no witnesses.

In charging the jury, the trial judge instructed them that if the greater weight of the evidence shows that the decedent, and one or both of the defendants were negligent and that the negligence of each contributed as a legal cause of the decedent's death, they should determine what percentage of the total negligence of all parties to this action is chargeable to each.

After weighing the evidence, the jury returned a verdict of \$215,000 to the deceased's wife and two children. It also found that the physician was 10% negligent, that the hospital was 23% negligent, and that the defendant himself was 67% negligent. Pursuant to these findings, the trial court entered a final judgment in the amount of \$70,950. On appeal, both the physician and the hospital

Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel, and Anthony J. McNicholas III, J.D., Associate Legal Counsel, Professional Insurance Management Co. (PIMCO), Jacksonville, Fla.

asserted that the decedent's acts in attempting to commit suicide were a contributing legal cause of his death and thus subject to the preceding instruction regarding the comparative negligence of the decedent. In rejecting this argument the appellate court reasoned that the physician and hospital were confusing the difference between a contributing cause in fact and a contributing legal or proximate cause. In explaining the difference between a contributing cause in fact and a contributing legal or proximate cause the court stated that conduct prior to an injury or death is not legally significant in an action for damages, unless it is a legal or proximate cause of the injury or death, as opposed to a cause of the remote conditions or occasions for the latter negligence. So it is with conduct of a patient which may have contributed to his illness or medical condition, which furnishes the occasion for medical treatment. That conduct simply is not available as a defense to malpractice which causes a distinct subsequent injury — here the ultimate injury, wrongful death.

Applying that analysis to this case, the court felt that the patient's actions in consuming the Valium, Darvocet and beer was not the legal cause of his death but merely served to furnish the occasion for the physician's and the hospital's later negligence in failing to properly treat him. This conclusion was predicated upon the uncontroverted testimony of the expert witness who testified that but for the hospital's and the doctor's negligent treatment of the deceased, he would be alive today. Since the patient's death would not have occurred "but for" the negligent acts or omissions of the hospital and the doctor, those acts and omissions must be deemed the cause of the injury. Stated differently, any conduct on the patient's part before he entered the hospital which contributed to his cardiac and pulmonary arrest and subsequent death was not a proximate legal cause of the damages sought in this case. Accordingly the findings of comparative negligence against the patient was reversed, and the original full amount of damages was reinstated.

Cover Notes

The cover of this issue features FMA Officers for 1981-82 wishing a "HAPPY NEW YEAR!" to each of you.

Pictured clockwise from the top center are: Sanford A. Mullen, M.D., President; Gerold L. Schiebler, M.D., Vice President; J. Russell Forlaw, M.D., Treasurer; T. Byron Thames, M.D., Immediate Past President; Luis M. Perez, M.D., Secretary; and Robert E. Windom, M.D., President-Elect.

It is their hope, and *The Journal's*, that 1982 will be a year of health and happiness for all FMA members and their families.



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TABLETS

Each prolonged action tablet contains: Phenylephrine Hydrochloride 25 mg
• Phenylpropanolamine Hydrochloride 50 mg • Chlorpheniramine Maleate 8 mg
• Hyoscyamine Sulfate 0.19 mg • Atropine Sulfate 0.04 • Scopolamine
Hydrobromide 0.01 mg • Each Ru-Tuss tablet acts continuously for 10 to 12 hours.

Symptomatic Relief of Sneezing and Nasal Congestion

Comprehensive decongesting, antihistaminic and anti-secretory reliever for patients with nasal, sinus and other upper respiratory irritation.

- Eases breathing
- Reduces sneezing
- Reduces tearing
- Dries the drip

One tablet b.i.d. gives round-the-clock relief to adults and older children (12 years and over).



RELIEVERS

Winter Respiratory Discomfort

RU-TUSS[®]

EXPECTORANT

Each fluid ounce contains: Codeine Phosphate 65.8 mg • (WARNING: MAY BE HABIT FORMING) Phenylephrine Hydrochloride 30 mg • Phenylpropanolamine Hydrochloride 20 mg • Pheniramine Maleate 20 mg • Pyrilamine Maleate 20 mg • Ammonium Chloride 200 mg • Alcohol 5%

Symptomatic Relief of Coughing with Nasal and Bronchial Decongestion

Full range symptom-reliever for patients with air way congestion in the upper chest as well as the nose and throat.

- Blocks the cough • Loosens mucus
- Reduces sneezing • Eases breathing
- Tasty, so it's easy to take



To Relieve the Symptoms of Winter Weather Upper Respiratory Distress

RU-TUSS[®] / RU-TUSS[®] TABLETS EXPECTORANT

RU-TUSS[®]

Tablets

DESCRIPTION

Each prolonged action tablet contains:

Phenylephrine Hydrochloride	25 mg
Phenylpropanolamine Hydrochloride	50 mg
Chlorpheniramine Maleate	8 mg
Hyoscyamine Sulfate	0.19 mg
Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours.

Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings).

OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdoses may produce convulsions and death.

ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.

HOW SUPPLIED:

Bottles of 100 Tablets

Bottles of 500 Tablets

Federal law prohibits dispensing without prescription.

NDC 0524-0058-01

NDC 0524-0058-05

DISTRIBUTED BY:

Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106

MANUFACTURED BY:

Vitarine Company, Inc.
Springfield Gardens, New York 11413

RU-TUSS[®]

Expectorant

DESCRIPTION

Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate	65.8 mg
(WARNING: MAY BE HABIT FORMING)	
Phenylephrine Hydrochloride	30 mg
Phenylpropanolamine Hydrochloride	20 mg
Pheniramine Maleate	20 mg
Pyriminamine Maleate	20 mg
Ammonium Chloride	200 mg
Alcohol	5%

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and expectorant preparation.

INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of upper respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rhinitis. Also, for the temporary relief of symptoms associated with hay fever, allergies, nasal congestion and cough due to the common cold.

CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an anti-hypertensive or antidepressant drug containing a monoamine oxidase inhibitor is contraindicated.

Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma and in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient should be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effect caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle or operating dangerous machinery (See Warnings). Caution should be taken with patients having hypertension, diabetes, hyperthyroidism and cardiovascular disease.

Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddiness, dryness of mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension, hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, and insomnia. Overdoses may cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and even convulsions.

DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours, not to exceed 10 teaspoonfuls in any 24-hour period.

Children 6 to 12 years of age: $\frac{1}{2}$ the adult dose, not to exceed 6 teaspoonfuls in any 24-hour period. Children 2 to 6 years of age: $\frac{1}{4}$ teaspoonful every 4 hours, not to exceed 3 teaspoonfuls in any 24-hour period. Children under 2 years of age. Use as directed by a physician.

HOW SUPPLIED: (16 fl. oz.)

Pint Bottles

Federal law prohibits dispensing without prescription.

NDC 0524-1010-16



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Shreveport, Louisiana 71106
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Many years experience funding leases for Doctors reflects repayment liabilities limited to minimum exposure, therefore eliminating the need for normal reserve accounts for losses and high lease fees; in fact, lease funding through American Medi-Lease requires No Down-Payment and monthly repayment is approximately 30 percent less than time-credit installments, offering Both the lowest investment cost and lowest monthly expense. We will assist you in authoritatively constructing the best possible lease for you individually, keeping consistent with a residual that would provide for "turn-over" every two or three years if desirable.

American "Medi-Lease" Automobile Plan -

LEASE: Lease to you individually or to your corporation, not requiring any (up front) monies or security deposits.

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TERMS: 24, 36, 48, and 60 months terms on applicable imports and domestics. (Example: Mercedes, Porsche, Datsun 280-ZX, Audi, Rolls Royce, Volvo, Large domestics, 4-wheel drive vehicles, Vans, and Motor Homes.)

ACCOUNTING: All lease payments due on either the 1st. or 15th. of the month eliminating calendar referral for disbursement of funds, and documentation furnished for passing the Investment Tax Credit to the Lessee.

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TURN-OVER: All lease terms are authoritatively constructed to provide for "turn-over" to another new vehicle approximately every two years without additional investment.

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EXAMPLE LEASE RATES

Based on current 1982 prices and availability. Most are luxury equipped to include AM-FM stereo radios, air conditioning and power assets.

Volkswagen, Rabbit	199.00 per month	Datsun 280-ZX	349.00 per month
Honda Accord 4 dr.	230.00 per month	Audi, 5000s	436.00 per month
Toyota, Celica GT Coe.	220.00 per month	Porsche, 924	487.00 per month
Cutlass/Regal	245.00 per month	Mercedes, 240 Diesel	479.00 per month
Riviera	385.00 per month	Cadillac Eldorado	489.00 per month
BMW-320i	350.00 per month	Mercedes, 380 SL	835.00 per month

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In the treatment of impetigo—

- **100% cure rate with Tegopen® (cloxacillin sodium)**
- **only a 60% cure rate with penicillin V-K**



As seen on admission



After one week of penicillin V-K therapy



Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. No treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

Brief Summary of Prescribing Information

TEGOPEN®
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular.

(12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® (cloxacillin sodium)	Given penicillin V-K
<i>Staphylococcus aureus</i>	(78 patients)	39	39
Returned to clinic at one week	29†	38†	
Treatment failure at one week	0	18 (47.4%)	
<i>Staphylococcus aureus</i> and <i>Streptococcus pyogenes</i>	(9 patients)	4	5
Returned to clinic at one week	4	5	
Treatment failure at one week	0	2 (40%)	
No initial bacterial growth	(14 patients)	9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic <i>Streptococcus</i>	(1 patient)	0	1
TOTALS:	102 patients	52 patients	50 patients

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported

the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus*, 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes*, and 1% beta-hemolytic *Streptococcus*.†
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.

- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

†The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®

(cloxacillin sodium)

—effective therapy for staph infections of the skin and skin structures

WARNING:

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:

The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:

Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose

stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:

Adults: 250 mg. q. 6h.

Children: 50 mg./Kg./day in equally divided doses q. 6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:

Capsules—250 mg. in bottles of 100. 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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January 29-30, 1982

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Cleveland Clinic Foundation, Cleveland, Ohio

JOHN HOLLIFIELD, M.D.

Vanderbilt University Medical Center, Nashville, Tennessee

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Cornell Medical Center, New York, New York

The seminar will present newer concepts, diagnostic techniques and treatment of arterial hypertension. The program is specifically designed for the evaluation of hypertensive patients in the office practice of primary care physicians, internists, cardiologists and nephrologists. Presentations will be made by an outstanding faculty with adequate opportunity for direct discussion and questioning.

6 C.M.E. Credits

For further information contact: Program Department, American Heart Association, Broward County Chapter, 440 N. Andrews Ave., Ft. Lauderdale, Florida 33301 (305) 764-7900.

Happy New Year

Time is seamless, with the past, present and future woven into the fabric of one's life. The present is rapidly disappearing into the past. We must learn that time is indivisible, that every act is a blending of past experiences, present situations and future expectancy.

Life is like a flowing stream, and like mariners, we must find the shoals, the rocks and the rapids. We must not look too far ahead nor too far behind, but must develop a delicate combination of learning from the past to live realistically in the present, and plan for the future without forfeiting it to barbarism or bestiality.

Having become a year older, Lord, may we not become senile or childish, yet let us, in the coming year, retain those traits of childhood such as curiosity, imagination and creativity. Keep our perception from being blunted by compromise, fatigue, or the mistaking of mere respectability for morality.

Handicaps that produce failures exist only in one's mind. So, with enlightened self-interest and human compassion, let us use our resources of time, money and

talents to strengthen the hands and amplify the voices of all those fighting for peace, protecting the environment and enlivening our culture and religious heritage.

Daily in the New Year, may we have a healthy and productive attitude. Let us not be deadly conformist in our thinking, nor static in our beliefs. Prevent us from failing to show verve, humor, insight or the capacity for genuine self criticism; and let us not pay homage just to riches, respectability, or power.

So, take counsel and take hope. The greatest miracle in the world is each of its more than three billion inhabitants. What will count is whether civilization in the atomic year of 1982 can summon up new leadership to deal with its many woes. One universal thought is man's dissatisfaction with himself and a striving to be better than he is. Civilization can survive only when and if this world's inhabitants so dream and plan and work.

*Clyde M. Collins, M.D.
Associate Editor
Jacksonville*

Welcome Back

The Impaired Physician Program of the FMA — FMF is progressing on schedule. Since January, thirty physicians have been or are being treated in the four-month program. Physicians are now being returned to their communities after successful completion of their rehabilitation programs. We can all feel good about the program, but what has been the response of the medical community when our colleagues return?

These problems have arisen. One physician left Florida and returned to Canada because he could not get a physician to monitor his work. One M.D. was suspended by the State Board of Medical Examiners after

one year of no drugs, following a delay of one year after he had violated his probation. One M.D. was fired from two jobs because someone told them he *had* a problem; he had completed four months treatment, and was doing well. One M.D.'s partners refused to accept him back after his completion of four months treatment. One M.D.'s hospital was threatening to remove his surgical privileges after he returned from four months treatment. A letter and a few phone calls helped him retain his privileges under one year probation.

We all recognize that there will be problems when an impaired physician returns from treatment. Often just

prior to the physician entering treatment, there have been cataclysmic events and much ill feeling. We must, however, try to give our returning colleague a chance to prove himself again. He desperately needs the encouragement of his peers as he returns to productive practice. He has paid the price, spent four months trying to turn life around, and now deserves another opportunity.

When our patients are recovering from alcoholism, we try to be supportive and encouraging. Do our own colleagues deserve less? Which of us, in similar straits, would not expect fair and compassionate treatment from another physician during the road back?

*Guy T. Selander, M.D., Chairman
FMA-FMF Committee on
Impaired Physicians
Jacksonville*

The Financial Charade of Home Health Care

There is a national trend toward greater use of home health care, a potentially less expensive and more humane alternative to nursing homes and hospitals in caring for the sick and elderly. The federal government now spends more than a billion dollars a year on home health care, over six times the level of six years ago.

A growing number of corporate chains have been setting up home care offices as quickly as fast food franchises. The original idea of home health care — that nurses' aides and therapists could hold costs to a minimum by treating patients at home — is being lost in the process. A federal survey of six high-cost cities taken in 1981 found that some corporations now charge as much as \$79.19 for a skilled nursing visit, and others (usually non-profit firms) offer the same service for as little as \$4.56.

In 1976, a Chicago attorney with an initial investment of just over \$1,000 went into the fledgling home health care program. The attorney's clever construction of interlocking health care companies enabled him to obtain millions of Medicare dollars. He then set up five non-profit health care offices in the Chicago area, rented them office furniture and sold goods and services at highly inflated prices through several profit-making subsidiaries that he also owned or controlled. A federal jury and U.S. Senate investigators tried to retrace the flow of illicit cash into the attorney's many repositories. More than a million dollars was deposited in a tax shelter in the Caribbean Islands beyond the reach of the U.S. federal auditors and tax collectors.

The story of the Chicago attorney, investigated in 1981 by the U.S. Senate Permanent Subcommittee on Investigations is more than the tale of one man's milking of Medicare. It is a demonstration of the ways in which

social programs like Medicare and Medicaid tend to invite fraud and abuse through complex reimbursement systems and weak audit controls. The Medicare program pays all home health care firms in advance, with cash up front, for the projected expenses of the coming year.

The reimbursement system of home health care relies on private insurance companies to determine which home care expenses should be paid and which disallowed. In the case of the Chicago attorney, Blue Cross auditors raised the right questions early in 1979 about the vague services and inflated rates. Why was this allowed to go on until 1981? Blue Cross did not have the power to enforce their recommendations that he was probably exploiting the home health care program. A home health care provider can challenge any expense rejected by his third-party insurer through a convoluted but sometimes rewarding appeals process. The home health care provider's legal bills are paid by Medicare and the third party insurance companies representing the government also charge legal and travel expenses to Medicare.

The major problems with the reimbursement system of home health care is that no incentive exists to hold down costs. The more one spends, the more one can charge to Medicare; cost-conscious firms merely end up with fewer dollars. Given the temptations, it is hardly surprising that some home care operators have charged the tax payers for everything from a vague assortment of training and consulting services, at an average cost of \$1,500 a month, to European vacations and country club dues.

The federal government should have learned from the rampant abuse in nursing home operations during

the 1970's that anti-abuse controls are essential. The real tragedy of home health care abuse is that one of the best ideas to come down the pike in years is in jeopardy. Namely, home health care permits the elderly to remain in the community with family and friends instead of shutting them away in concrete institutions.

The Reagan administration has signaled its support for the home care concept and is pushing a Medicaid cap that merely shifts the burden of rising costs to the states.

The financial nuts and bolts of the health home care system need to be tightened considerably, and the bureaucratic maze governing the program streamlined. Non-profit firms should be prevented from funneling monies to their corporate subsidiaries. The program must redesign the absurd system that can allow people like the Chicago attorney to ripoff the home health care program and then invest in foreign tax havens with tight bank secrecy laws.

*Edward Pedrero Jr., M.D.
Assistant Editor
Tampa*



A tax-favored approach to post-retirement protection.

Introducing the exclusive FMA-sponsored Retired Lives Reserve.

"The FMA is proud of the many innovations it has pioneered on behalf of our members. We are pleased to present another, exclusively for you, designed to provide you with substantially greater financial flexibility, more secure estate maintenance, and peace of mind. I highly recommend the exclusive FMA-sponsored Retired Lives Reserve for your serious consideration."

Sanford A. Mullen, M.D.

Sanford A. Mullen, M.D.
President, Florida Medical Association

A dramatic new tool for personal and estate planning.

FMA and MAPS (the Mutual Association for Professional Services) are proud to offer an imaginative and innovative program designed to significantly strengthen your estate planning. It's a special version of The Penn Mutual Life Insurance Company's Wraparound Retired Lives Reserve, customized to provide meaningful benefits to FMA members, age 65 or less. It offers substantial lifelong coverage, low premiums, tax-favored status, and assured estate maintenance. It's a program exclusively and specifically for FMA members. No other organization can offer it.

Continuing protection. For life.

That's important. And unusual. Group term life insurance coverage by its very purpose and nature terminates or drastically diminishes when you retire. And the cost of continued coverage can be prohibitive. The FMA-sponsored Wraparound Retired Lives Reserve, on the other hand, picks up coverage on a pre-paid basis *even after you retire and stop paying premiums.*

Coverage up to \$300,000.

Most members can elect coverage up to \$300,000! That's another special feature not available in so-called "similar" programs.

Tax-deductible premiums.

One of the most advantageous—and unique—features of the FMA-sponsored Retired Lives Reserve is its tax-favored position. The premium rates, to begin with, are extremely attractive. And their tax-deductible status to corporations reduced your actual cost even more.

Your estate is protected. And productive.

High-value continuing coverage and tax-deductible premiums are obvious advantages. But there's more. Consider also that your post-retirement coverage provides a potential source of income-producing assets to your estate for your heirs. And the surety of a solid estate base allows you the option of converting other policies to annuity status for additional retirement income.

For FMA members only.

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State

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Best time to call

(day)

(time)

a.m.

p.m.

Compared to ampicillin

Faster peak. Fewer problems.

... in adults and children

Cyclapen®-W (cyclacillin) produces peak serum concentrations* almost four times higher and over one hour earlier.³

Cyclapen®-W is just as effective in otitis media, bronchitis, pneumonia, urinary tract infections and infections of skin and skin structures†.³

Cyclapen®-W produces a significantly lower incidence of diarrhea and skin rash.³

CYCLAPEN®-W
(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.

*Rapidly excreted unchanged in urine. Clinical efficacy may not always correlate with blood levels.

†Due to susceptible organisms.

3. Data on file. Wyeth Laboratories.
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See important information on adjoining page.

Wyeth Laboratories
Philadelphia, Pa 19101

Compared to amoxicillin

Faster peak. Fewer problems.

... in infants and children

Cyclapen®-W (cyclacillin) produces twice the peak serum concentration* (15.6 mcg/ml versus 7.3 mcg/ml) in half the time (30 minutes versus 60 minutes).¹

Cyclapen®-W is just as effective in otitis media and streptococcal tonsillopharyngitis†.²

Cyclapen®-W produces a significantly lower incidence of the most common side effect, diarrhea.²

CYCLAPEN®-W
(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.

*Rapidly excreted unchanged in urine.
Clinical efficacy may not always correlate with blood levels.

†Due to susceptible organisms.

1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC. Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.

2. Multicenter trials. Data to be published.

See important information on page after next.

Cyclapen®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications. Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Branchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis* (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Branchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day† q.i.d.
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.

†depending on severity

How Supplied Tablets 250 mg and 500 mg in bottles of 100. Oral Suspension 125 mg and 250 mg per 5 ml in bottles to make 100 ml and 200 ml of Suspension.

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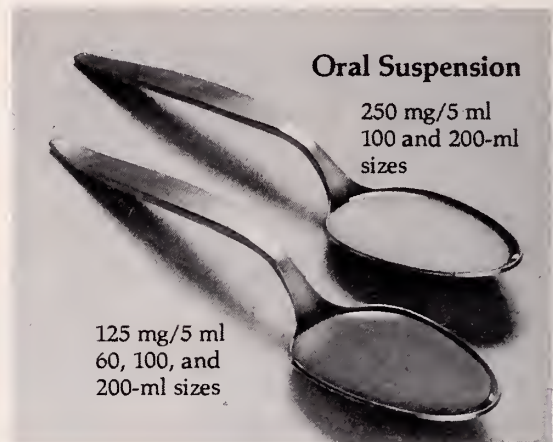
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Institutionally-Based Diabetes Educational Services for Patients and Their Families in Florida

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Abstract: Three hundred and sixty-one Florida hospitals, nursing homes, county health units, home health agencies, and other medical institutions participated in a survey to determine the content, personnel and resources of diabetes education services. Of the responding institutions 44 percent had outpatient and 60 percent inpatient educational activities serving an average of 4054 patients per week. Eighty percent of the primary diabetes educators are nurses. Sixty-three percent of the institutions have a team approach. Most patient instruction is on an individual basis, lasts one to two hours, and takes place in the patient's room. The quality of available printed and audiovisual materials generally are considered to be good. Topics frequently covered include: diabetes causation, medications, hypo/hyperglycemia, diet and nutrition, urine testing, foot care and hygiene. The most common problem encountered is the lack of adequately trained personnel. The most frequently requested types of assistance from the Diabetes Centers are educational materials and patient and professional curriculum development.

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The Diabetes Centers Act of 1976 established Centers at the University of Miami (UM), University of South Florida (USF) and the University of Florida (UF) Medical Schools. Funding was obtained in 1979 to pursue the mandated goals:

- I To train medical students, nurses, pharmacists, dietitians, social workers and personnel of medical fields in the care and management of patients with diabetes.
- II To provide continuing education in the treatment of diabetes mellitus.
- III To educate patients with diabetes mellitus, relatives of the patients, and the general public concerning diabetes and its complications stressing the importance of nutrition and

physical fitness in the prevention and control of diabetes mellitus as well as improving the overall quality of life for the citizens of Florida.

- IV To provide outpatient facilities for treatment of patients with diabetes mellitus referred by physicians and other health agencies.
- V To provide and upgrade inpatient services for diagnosis and treatment of patients with diabetes mellitus.
- VI To provide treatment for medically indigent patients with diabetes mellitus, including those that may be referred from the county health departments.
- VII To conduct research in diabetes mellitus.
- VIII To provide consultation and medical support for the Department of Health and Rehabilitative Services in treatment of diabetes mellitus.
- IX To establish a statewide surveillance and monitoring system for diabetes mellitus and its complications and to provide incidence, prevalence, mortality, and morbidity information and economic impact data for individuals with diabetes mellitus throughout the state of Florida.

Initial contracts between the Diabetes Centers and the Department of Health and Rehabilitative Services (DHRS) called for a survey of diabetes educational activities and needs. A survey was needed to develop appropriate educational plans for the Centers to assist persons throughout the state in educating patients with diabetes in self-management and preventive practices.

This report summarizes the findings of the statewide survey and presents recommendations based on the survey results. A more detailed report is available on request.

The purposes of the survey were to determine the extent of participation of health care institutions in diabetes education, identify personnel involved in diabetes patient education and their resources, establish a network of persons interested and/or engaged in diabetes education, and make recommendations for developing and increasing the number of diabetes patient educational services and programs.

Methods

A small pilot study of the survey instrument was conducted in the Gainesville area in February 1980 and a final instrument produced (available on request). Approximately 745 survey forms were mailed by the three Centers (in March 1980) to hospitals, nursing homes, health maintenance organizations, home health

agencies, county health units, rural/migrant health clinics, area health education centers and other health-related institutions throughout the state.

Cover letters explaining the goals of the Diabetes Centers and the need for the survey were sent to the Hospital Chief of Staff, Medical Directors or Chief Administrators of other health care institutions, Directors of Nursing at Hospitals and County Health Units and Chief Dietitians at Hospitals. Names and addresses were obtained from the DHRS Office of Licensure and Certification and *Clark's Directory of Southern Hospitals*, 1980 edition. Previous studies indicated that nurses are the primary health educators.^{1,2} Our cover letters requested the Chiefs of Staff and Dietitians to assist the Director of Nursing in completing the survey.

Telephone follow-up in March and April yielded a high final total return rate of approximately 48%, or 361 surveys. One hundred sixty-one surveys (52.6% return) were received by the UF Center; 73 surveys (44.0%) returned to the UM Center, and 127 surveys (48.4%) returned to the USF Center. Survey forms received by the individual centers were logged, reviewed for important information and then sent to the UF Center for processing.

Five recorder/coders were trained and checked for inter- and intra-individual recorder errors three times during the recording/coding period May-August, 1980. For each check, all five coders were given the same three surveys to code and the percentage of discordant responses was noted. The mean inter-individual error rate was 5% with a range from 3% to 10%. Errors in coding rather than errors in recording were more frequent. Intra-individual error rates were assessed on three separate occasions by having each recorder/coder code the same survey twice with a lapse of approximately one week between codings. The intra-individual error rate averaged 3%, with a range of 2% to 12%. Questions which required interpretation (e.g., requests for assistance) were subject to greater inter- and intra-individual error rates.

Data validity checks were made by comparing four pairs of hospital surveys returned by different respondents from the same hospitals. Hospitals were the units chosen for this check because, in general, surveys from hospitals had a higher completion rate. One hundred ninety-three variables were recorded. The number and percentage of discrepancies among the respondents were: Dietitian/Nurse (n=29, 15%), Patient Educator/Director of Food Services (n=90, 47%), Patient Educator/Dietitian (n=80, 41%), and Director of Food Service/Administrator (n=49, 25%). Although these percentages appear high, 69% of the discrepancies were omissions rather than differing responses, in which one of the respondents simply did not answer the question. A

follow-up survey of all 67 County Health Units corroborated the findings in this survey that the best completion rates occurred among nurse respondents with poorer completion rates for dietitians and physicians.

Data were analyzed using the Statistical Analysis System (SAS).

Results

Responding facilities based on the DHRS Office of Licensure and Certification (1979-1980) listings included: 62.4% (n=158) of all licensed hospitals in Florida, 28.3% (n=97) of licensed nursing homes, 47.8% (n=32) of county health units and 36.4% (n=52) of home health agencies. The most frequent type of hospital respondent was the nonprofit hospital (n=59) followed by proprietary hospitals (n=51). Fifty-nine of 67 Florida counties had one or more units returning the survey. All 11 HRS districts were represented.

A nonrandom response bias was noted by Cyr, Gjullin and Burmeister (1979)³ in a national mail survey of nursing homes. The biased return rates in the Florida survey correspond well with their findings of bias in favor of larger facilities based on the number of beds. They also found that their sample had an over-representation of nonprofit and corporate-owned (proprietary) nursing homes and homes with a higher patient care level based on Medicare/Medicaid classifications. Similar biases appear in our sample.

Survey Respondent

A variety of occupations were represented among the survey respondents. Most numerous were nurses

(33%) and least numerous were physicians (2%). A large group (23%) designated as "others" included primarily nurses. These individuals had titles such as "In-Patient Services Coordinator," "Patient Health Educator," and "Patient Education Coordinator". Most non-physician administrators (26%) were heads of nursing homes or home health agencies. Physician administrators headed hospitals. In general, the respondent was the person primarily responsible for diabetes education and, therefore, the most knowledgeable concerning the educational programs at his/her institution.

Patient Load

The total estimated number of patients served per week in 351 reporting institutions was 4,054. Of these, 1,215 were insulin-dependent (ID) inpatients, 846 were ID outpatients, 1,185 were noninsulin dependent (NID) inpatients and 808 were NID outpatients. * The highest average weekly load of 832 patients per week occurred in District IV. The lowest reported weekly patient load of 91 patients was from District IX. One hundred forty-seven units reported treating NID outpatients, 215 treated ID inpatients, and 154 served NID inpatients. In sum, almost one third more institutions report treating ID than NID patients (Table 1). Twice as many units have outpatient services only (42.4%) compared to inpatient services only (22.3%). Over one third of the institutions (35.3%) report treating both inpatients and outpatients.

*The numbers reported appear disproportionate to the known prevalence of true insulin-dependent diabetes in the population. We suspect that all insulin-taking patients were included in the category of ID even though the guidelines indicated they should be ketosis-prone.

Table 1. — Average Patient Load per Week by District for Responding Institutions.

HRS District	Inpatient		Outpatient		District Patient Totals
	Insulin Dependent	Noninsulin Dependent	Insulin Dependent	Noninsulin Dependent	
1	38	30	64	34	166
2	49	27	47	62	185
3	149	133	83	73	436
4	241	221	179	191	832
5	126	123	55	54	358
6	91	95	68	134	388
7	138	126	48	59	371
8	150	198	54	53	455
9	42	34	14	1	91
10	115	108	72	100	395
11	78	90	162	47	377
Patients Totals	1,215	1,185	846	808	4,054
Facilities	215	154	208	147	351

Survey respondents were asked to indicate whether patient records, diet records, both of these or some other information was used to estimate patient loads. Two hundred units (71.2%) used patient records, 29 (10.3%) used diet records, 35 (12.5%) reported the use of both patient and diet records, and 17 (6%) used some other source such as a patient roster.

Seasonal Variation

One hundred twenty-six (43.4%) institutions, representing all districts, reported seasonal variation. Of those institutions reporting seasonal variation, 81.2% reported that loads increase in the winter.

There is no pattern to indicate whether summer or winter increases are localized. However, District XI at the southern tip of the state had the greatest number of institutions reporting seasonal variation (75.0%, n=12). The actual weekly average loads in District XI were a high of 275 patients-week and a low of 167.

Patient Age Groups

Ninety-nine percent of reporting institutions treated adults, with almost 50% treating only older adults. Only 28% of reporting institutions treated adolescents and 23% treated children. Because nearly one third of the reporting institutions are nursing homes, there is a skewed distribution of institutions treating older adults. In general, hospitals treat children, adolescents, young adults and older adults. Home health agencies, county health departments, and rural health units also treat patients in all age groups.

Educational Services

In response to the question, "What type of diabetes education does your facility provide?" 44% (n=154) of the units report services or programs for outpatients and 60% (n=210) for inpatients. Seventeen percent of all reporting units state that they have no inpatient or outpatient programs. Individual respondents determined whether or not their units offered educational services or a formal diabetes educational program. In general, programs had educational teams, a participating health educator, group instructional sessions, and written educational objectives.

Types of Instruction

Ninety-six percent of reporting units (n=285) offer individual instruction. The proportion of institutions offering family instruction decreases to 76% (n=231). Only 25% (n=72) offer group instruction. Of those units offering group instruction, 7% have daily sessions, 26% weekly sessions and 24% monthly sessions. The other

43% of these institutions hold group instruction at biweekly intervals or at intervals greater than one month apart.

Group size varies considerably. Fifty-one institutions (59%) report one to ten persons per session; 27 (31%) report ten to 20 persons per session; seven (8%) report 20 to 50 persons per session; and one reports 80 to 100 persons per session.

Most instructional sessions last one to two hours for both inpatients (74%, n=136) and outpatients (80%, n=120). The remaining institutions, 11% (n=21) have three to four hour inpatient sessions and 19% (n=27) have some other duration, either shorter than an hour or longer than four hours. With outpatient instruction, 7% (n=11) of institutions have three to four hour sessions and 12% (n=18) have sessions either shorter than an hour or longer than four hours.

Sources of Referral

Physicians were most frequently ranked first as the source of patient referral into diabetes educational programs (51%). Ranked second was hospital staff (44%), third was self-referral (41%). However, a sum of the percentages of first, second and third ranks indicates that hospital standing orders account for 81% of referrals, hospital staff for 79%, physicians for 78% and self-referral 71% of the top three rankings. In contrast to the other institutions, relatives or another hospital are the primary referral sources for individuals receiving instruction in diabetes education in nursing homes.

Primary Diabetes Educator

Nurses were most often the primary diabetes educators (Table 2). Eight percent (n=22) of the primary diabetes educators had some other designation than those offered in Table 2 including Food Service Supervisor, Patient Service Coordinator, Staff Development Supervisor and Patient Education Coordinator. Most of these individuals were trained primarily as nurses (R.N. or B.S.N.). Thus, greater than 80% of those responsible for primary diabetes education are nurses.

Table 2. — Number and Percent of Institutions Reporting Primary Diabetes Educators

EDUCATOR	#	%
Nurse	172	63.0
Dietitian	28	10.2
Health Educator	44	16.1
Physician	5	1.8
Director/Administrator	2	0.7
Other	22	8.0

Only 10% of the reporting units (n=28) had dietitians in charge as primary educators. Health educators were primary diabetes educators in 16% of the reporting institutions, usually where there were formal programs.

Of 244 institutions, 62.5% indicated that they have a team approach to diabetes education. The range of facilities having a team approach varied from 47.1% to 84.6% by district.

Physician and Nurse Participation in Diabetes Education

Numerous physicians on staff in the various reporting units do not actively participate in the teaching and/or planning of educational activities for patients. For example, 68% of the general or family practice physicians on staff participate in diabetes education: this usually took the form of counseling, but not planning of educational sessions. This was also true for 56% of the ophthalmologists, and 33% of physicians of some other specialty (e.g., surgeon, cardiologist). Only 26% of staff pediatricians are participating in diabetes educational programs. Overall, the survey indicates that there is an underutilization of physician resources.

The relatively low physician involvement contrasts with the number of nurses involved in teaching; 91% of responding institutions indicated that registered nurses are involved extensively in teaching and planning. Only 4% of the institutions indicated that they had R.N.'s on staff who were nonparticipants in educational programs.

It is difficult to come to a definitive conclusion concerning the involvement of professional specialists in diabetes education. In part this is because a number of respondents did not answer the question concerning

participation of health specialists. In addition, many smaller units, such as nursing homes, do not have these specialists on staff, but use specialists as consultants.

Health-Related Professionals and Educational Services

Table 3 lists nonphysician and nonnurse health specialists. In some instances specialists were checked on the survey form, but there was no indication of their role in diabetes education. Of the reporting institutions, 51% (N=139) indicated that a pharmacist is on staff but is not part of the teaching team while 54% of the units indicated physical therapists are on staff but are not part of the teaching team. These two specialists represent the largest number of health-related professionals who are on staff but not active in diabetes education. In contrast, registered dietitians are used by 70% of the facilities for teaching or for full participation in educational services.

Teaching Locus

Of the 302 institutions reporting, 169 (55.9%) had some space allocated to teaching activities with 62% indicating that the patient's room is used for education. Classrooms and conference rooms are used in about one fourth of the institutions. Most institutions are in need of space specifically designated for educational activities.

Budget

Only 15 institutions (5.4%) had their own educational budget. The most important source of educational financing comes from general hospital revenues. Ninety-four responding institutions ranked hospital revenues

Table 3. — Number and Percent of Institutions Reporting Health Professional Participation in Diabetes Education, All Districts.

Specialty	Not On Staff		On Staff No Participation		Some Participation*		Full Participation**	
	#	%	#	%	#	%	#	%
Diabetes Educator/Counselor	75	56	2	1	20	15	37	27
Registered Dietitian	25	13	12	6	73	27	85	43
Dentist	58	46	56	44	5	4	6	5
Pharmacist	29	20	72	51	12	8	26	18
Clinical Psychologist	80	65	31	25	3	2	8	6
Physical Therapist	34	24	78	54	15	10	16	11
Occupational Therapist	74	56	42	32	9	7	7	5
Recreational Therapist	85	66	32	25	6	5	4	3
Psychiatric/Social Worker	84	65	29	22	5	4	10	8
Medical Social Worker	53	39	51	38	17	12	12	9
Community Health Worker	83	73	13	11	7	6	10	9
Other (eg. Patient Ed. Coord., Food Service Superv.)	8	15	3	6	16	24	23	44

*Some participation — limited to individual and family instruction.

**Full participation — including planning educational sessions and individual and family and group instruction.

either first, second or third 48% of the time. Medicaid and Medicare are also sources of funding. Some funding comes through monies allocated to the dietary departments. In nine cases, grants ranked first as a funding source.

Topics

Over 85% of the institutions report teaching about diabetes causation, symptoms, insulin reaction, diabetic coma, exercise, foot care, hygiene and nutrition, urine testing and other topics listed in Table 4. Of the responding institutions, 94% indicated that they use the ADA exchange list when instructing patients about nutrition and diabetes. Fewer educational programs cover problems of alcohol consumption, eating out, sexual functioning, pregnancy, or the many psychological issues involved in the long-term care of diabetes.

Table 4. — Content of Diabetes Education*

Topic	*Always and Frequently Taught
Causes of Diabetes	84 %**
Diabetes Symptoms	89
Hyperglycemia	88
Hypoglycemia	86
Insulin Types and Administration	89
Oral Medication Types and Administrations (Adult)	78
Urine Testing: Glucose	89
Urine Testing: Ketones	84
Nutrition: Nutrient Content of Foods/Balanced Diet	95
Nutrition: Exchange Lists (ADA)	94
Nutrition: Weight Control	86
Nutrition: Preparation/Menu Planning	88
Nutrition: Alcohol	64
Nutrition: Eating Out	77
Exercise	87
Foot Care	88
Hygiene (Personal)	89
Hygiene (Dental)	74
Insulin Reaction/Diabetes Coma	91
Sick Days Management	63
Psychological Issues: Emotional Stress/Self-Concepts	62
Psychological Issues: Family Dynamics	49
Sex Education	16
Pregnancy	20
Daily Living (School, Travel, Vacations, etc.)	66
Other	73

**%of reporting units that frequently and always teach topic.

Quality of Educational Materials

The most frequently used educational materials are pamphlets, books, flipcharts and food models. Approximately 40% of the respondents answered the question concerning the quality of these educational materials. In addition to rating the materials as either good or bad, a check-off column was used to indicate if a respondent did not know of materials for a particular topic. For example, 40% of the respondents indicated that they could not appropriately rate the materials involving psychological issues. Although the response set is small, the responses indicate that those materials covering topics that are always or frequently taught also are considered to be of higher quality (Table 5).

Educational Techniques

Of responding units, 45% indicated that demonstration was a major teaching technique (n=114). Only 23 institutions (9.5%) used role playing and only 3.8% had phone taped instruction. When institutions had full-fledged programs in diabetes education, a variety of techniques and activities were used. Written tests are used in nearly one half of the outpatient programs. Very few programs and services use no educational evaluation techniques. The exceptions are institutions which offer inpatient services but not programs (52%).

The most frequently used teaching and evaluation techniques involved verbal feedback (74%, n=204) from the patient to the instructor and demonstration of techniques, such as insulin injection and urine testing. Other frequently-used sources of evaluation are the diet and urine records, clinical status based on examination and medical history, and the use of some sort of written testing procedure. Of responding institutions, 91% (n=258) routinely recorded educational sessions in the patient records.

Most (86%) full-fledged programs had written educational objectives both for the instructor and the patient. Overall, 39% of reporting institutions (n=110) indicated that they had written objectives.

Follow-Up and Evaluation

The greatest contrast in long-term follow-up procedures occurs between educational services and educational programs. In those units offering educational services only, approximately 50% of them do not have any standard follow-up procedure. When procedures are instituted, the most frequent follow-up is a scheduled return visit with a physician and/or some other health care practitioner. Much less frequently, individuals are referred to the American Diabetes Association or have telephone contact with other individuals involved in diabetes education. Few programs document the effect

of education with long-term follow-up testing. Programs rarely have any formal technique for evaluating the educator or the educational instruments which are used.

Educational Problems

Respondents were asked to rank the major educational problems they encounter. Educational problems for both inpatient and outpatient activities most frequently included a lack of trained personnel, lack of patient referral, and problems with non-English speakers and readers. Sixty-three percent of the respondents indicated that a lack of trained personnel was the most important problem. Lack of adequately trained personnel was ranked first by 52 institutions (40.3%). The lack of appropriate educational materials was ranked first by only 22 institutions (20.2%). However, when respondents were asked about potential assistance from the Diabetes Centers, they ranked the development of educational materials first.

Reading level was ranked as the primary problem by 29 institutions (21.8%). Comprehension was the primary problem noted by 42 institutions (24.3%). Language difficulty for non-English speakers was ranked first by 55 institutions (29.6%), and misinformation and beliefs concerning diabetes ranked first as a problem by only eight institutions. A lack of referral into diabetes educational programs was ranked first by 31 institutions and overall 47% of the responding institutions ranked it as a problem. Other problems included lack of space and time.

Assistance Desired from the Diabetes Center

Since the Diabetes Research, Education and Treatment Centers have the mandate to educate health care professionals involved in diabetes education and patient management the survey asked, "How can the Diabetes Centers assist you with educational programs for patients?" Educational materials were requested most frequently. There is a particular need for educational materials for non-English speakers and English speakers with limited reading abilities. Nurses and dietitians indicated a need for assistance in patient curriculum development. Professional curriculum development was mentioned frequently as was educational program administration. Workshops for health professionals other than physicians were considered important forms of assistance which could be provided by the Diabetes Centers.

Comparisons with Other Surveys

The present survey of Florida's diabetes educational resources was based, in part, on a nationwide survey of diabetes educational programs conducted by the

Table 5. — Quality of Diabetes Educational Materials.

Topics	%Good Quality
Cause of Diabetes	83
Diabetes Symptoms	83
Hyperglycemia	82
Hypoglycemia	82
Insulin Types and Administration	80
Oral Medication Types and Administration (Adult)	69
Urine Testing: Glucose	84
Urine Testing: Ketones	80
Nutrition: Nutrient Content of Foods/Balanced Diet	84
Nutrition: Exchange Lists (ADA)	88
Nutrition: Weight Control	74
Nutrition: Preparation/Menu Planning	75
Nutrition: Alcohol	49
Nutrition: Eating Out	58
Exercise	60
Foot Care	72
Hygiene (Personal)	69
Hygiene (Dental)	46
Insulin Reaction/Diabetes Coma	80
Sick Days Management	44
Psychological Issues: Emotional Stress/Self-Concepts	41
Psychological Issues: Family Dynamics	30
Sex Education	19
Pregnancy	30
Daily Living (School, Travel, Vacations, etc.)	54
Other (Specify)	42
Approximately 40% of Units Reporting	

University of Virginia Diabetes Research and Training Center in 1979.⁴ Seventy-five percent of their respondents were nurses compared to approximately 80% of our respondents. Seventy-five percent of the programs were hospital or health center based and 50% had begun within the last five years. Two thirds of their responding institutions treated both inpatients and outpatients while only one third of our respondents treated both patient types. Half of the respondents to the nationwide survey reported treating children. In Florida, only one fourth of the institutions reported offering services for children.

Since the Virginia nationwide survey included only diabetes educational programs, development of curriculum, duration of instruction and involvement of personnel in general exceed numbers found in our more general survey. As in the Florida diabetes survey, nurses were the most frequently used educators, followed by dietitians and physicians. However, more of these programs had a full-time physician and 50% of the programs had two to three people involved on a regular (at least half time) basis. Most of the programs offered

Continuing education both for patients and professionals (primarily nurses, other allied health professionals, and dietitians).

Only 40% of the institutions in the Virginia study had their own budget. Primary sources of funding were first, general hospital revenues; second, patient payments; and last, third party payment. In Florida, Medicare and Medicaid were more important sources of funding. In summary, those facilities in Florida that do offer diabetes educational services and programs are similar to those in other states as described by the National survey.

An earlier nationwide study of hospital-based inpatient educational programs was conducted by the Department of Health, Education and Welfare and the American Hospital Association (1975)¹. Diabetes education programs were 50% more frequent than the next most frequent program type (listed as nutrition) of ten types of adult education programs. A total of 2,097 hospitals reported having adult diabetes programs and 960 reported having pediatric diabetes educational programs. Physician and staff referral were the most common ways people entered these programs. Most programs used classrooms or multipurpose areas. The most frequently used materials were films, pamphlets and other audiovisual materials. Most teaching was done on an individual or family basis. About one third of the hospitals also reported small group instructional sessions. As in the Florida and Virginia studies, registered nurses and dietitians were most frequently the primary educators. Nearly 80% of the hospitals assessed the impact of their education by observing patients demonstrate skills or tasks. This is comparable to the findings of the Florida survey.

A more limited study conducted by Heller and Brown² for the Joslin Diabetes Research and Training Center (1981) focused on diabetes education for nurses. Of nurses contacted, 95% were interested in continuing education in diabetes education and management. The ability to obtain continuing education units and costs were primary concerns. They preferred one day sessions with lectures by nurses and dietitians on hypo/hyperglycemia, problems of childhood diabetes management, educational techniques, diabetes diagnosis and detection, and ketoacidosis. Most nurses found out about courses through direct mailing and through professional organization newsletters, journals and meetings.

Although the Florida survey focused on institutions, many patients with diabetes are treated by private physicians who may offer education and counseling services as part of a diabetes management program. In 1977 an estimated 11.0 million office visits were made at which the principal or first listed diagnosis was diabetes mellitus (National Center for Health Statistics, 1980)⁵, 69% were made by patients 55 years of age and older. Over

50% of the visits were to general or family practice physicians and an additional one fourth were to specialists in internal medicine. However, only 37% of these private physician visits involved some form of education or counseling. Seven percent of the therapeutic services are listed as other and many include some education (e.g., family planning, psychotherapy). It is unlikely that a substantial amount of patient education occurs within the severe time constraints of the private physician office visit, unless there is a group practice emphasis on diabetes permitting an educational program to develop with nurse and dietitian help.

Summary

1. Hospitals returned the survey with more frequency (generally two to three times) than did other health care institutions.

2. Half the respondents are nurses.

3. An estimated weekly average of the number of patients seen in the responding units is 4,054 with approximately 50% more inpatients than outpatients.

4. All reporting institutions treat adults but only about one fourth treat children and adolescents.

5. Forty percent of the institutions report having outpatient diabetes educational services and programs, and 60% of the institutions report having inpatient services and programs.

6. Ninety-six percent of the units have individual instruction but only 25% offer group instruction.

7. Most patients are referred to educational programs by hospital standing orders, hospital staff, physicians or themselves.

8. Most educational sessions last one to two hours and a series of sessions usually does not exceed ten hours.

9. The primary diabetes educator is usually a nurse but may often be a dietitian or a health educator.

10. Sixty-three percent of institutions with educational services and programs report a team approach. These teams often include nurses, dietitians, health educators, general or family practice physicians, physical therapists and social workers.

11. Most teaching takes place in the patients' rooms, conference rooms or classrooms.

12. Only 5% of the institutions report having a separate educational budget. Most education is supported by general hospital revenues or from direct patient payments.

13. The topics most frequently covered in educational sessions include diabetes causation, medications (including insulin), hypo/hyperglycemia, diet and nutrition-related topics, urine testing, exercise, foot care and hygiene. Psychosocial topics (i.e., family dynamics, stress management, sex education) are rarely discussed.

14. In general, most respondents stated that the quality of materials available is good for frequently discussed topics.

15. The most frequently used educational materials are pamphlets followed by books, flipcharts and food models.

16. A variety of educational techniques are used including demonstration, verbal feedback, pre- and post-tests, urine and diet records. Many of these techniques are also used to evaluate educational experiences.

17. The most frequently used follow-up procedure is to schedule a visit with a physician or other health care professional.

18. The most frequent educational problem encountered is a lack of trained personnel, followed by problems of lack of referral and communication with non-English readers and speakers.

19. The most frequently requested form of assistance from the Diabetes Centers is the provision or loan of educational materials. Patient and professional education curriculum development is another major need.

Acknowledgments

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Recommendations for the Diabetes Centers

1. The development of training programs and materials for health professionals on the implementation and administration of diabetes educational programs.

2. The encouragement of increased involvement of health care specialists who are on staff in various facilities but who are not included in diabetes educational activities.

3. The development of educational materials particularly pamphlets, books, slides, slide-tape presentations and videotapes which cover topics such as: alcohol use, exercise, insulin reaction and diabetic coma, sick day management, sexual function, and a variety of psychological issues including stress, self-concept and family relations.

4. The development of materials in Spanish for the large Hispanic population in Florida. Materials may need to be developed in Yiddish and Creole.

5. The institution of regional networks for diabetes information exchange.

6. The encouragement of third-party payment for educational services and the establishment of appropriate budgets for these services.

Pheochromocytoma, Diagnosis and Treatment Update and Case Report

Brad Bjornstad, M.D.; Jim Wade, M.D. and Yvonne Cummings, M.D.

Abstract: In recent years several new techniques for the preoperative and intraoperative management of pheochromocytoma have been found to be safe and effective and to offer advantages over the older methods employed with this rare but treatable cause of hypertension. Preoperative blood pressure control with prazosin hydrochloride has been shown to be effective and to avoid some of the side effects of older agents. Tumor localization with computerized axial tomography is as accurate as with older angiographic techniques and avoids many of the risks. Intraoperative blood pressure control with sodium nitroprusside results in more rapid and precise response to the fluctuations in pressure that may occur. The case report demonstrates the use of these newer techniques and a brief discussion follows of the rationale for their use.

A number of newer approaches to the diagnosis and management of pheochromocytoma have been described in the recent literature. These include the use of prazosin hydrochloride in preoperative management, computerized tomography (CT) for tumor localization, and sodium nitroprusside (SNP) during the intraoperative period.^{1,7} We report a case in which these modalities were successfully employed in a patient with pheochromocytoma of the left adrenal gland.

Case Report

This 55-year-old Caucasian male was referred to the James A. Haley Veterans Administration Hospital in Tampa for evaluation of poorly controlled hypertension. He had a four-year history of hypertension originally controlled with diuretics alone. His blood pressure had been noted to be very labile and over the past year had required therapy with a variety of antihypertensive agents.

On initial evaluation in the hypertension clinic, he gave a history of intermittent bitemporal headaches, nausea, dizziness, diaphoresis, tremulousness, anxiety

and orthostasis. He denied weight loss, fever, palpitations or flushing. Significant past medical history included a left upper lobe lung resection in 1971 for alveolar cell carcinoma and adult onset diabetes mellitus since 1977. There was no family history of hypertension; one brother had adult onset diabetes mellitus. The patient was started on prazosin 1 mg twice daily and chlorthalidone 100 mg daily. The prazosin was increased to 2 mg twice daily resulting in control of the patient's blood pressure without orthostatic symptoms. A 24-hour urine was obtained at this time for vanillylmandelic acid (VMA), metanephrines, and catecholamines. The results were markedly elevated (Table 1). The patient was admitted for further evaluation and treatment of suspected pheochromocytoma.

On physical examination, the patient was well developed, well nourished and in no distress though obviously anxious and slightly diaphoretic. Blood pressure was 208/140 mm Hg sitting and 180/120 mm Hg standing. Repeat blood pressure following abdominal pressure was 195/130 mm Hg. The patient admitted to not taking his medication the day prior to admission. His pulse rate was 90 beats per minute and regular. The remainder of the physical examination was normal with exception of a grade I hypertension retinopathy (Keith-Wagner-Barker Classification). Admission laboratory data included: hematocrit 48.4%; leukocyte count 11,300/cu mm; fasting blood sugar 205 mg/dl; and normal levels of electrolytes, creatinine, BUN and calcium. A

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repeat 24-hour urine for VMA, metanephrines and catecholamines was obtained, again with marked elevations in all levels (Table 1). Thyroid function tests, oral cholecystogram, electro-cardiogram, blood volume determination, and a previously done intravenous pyelogram were all normal. CT scan of the abdomen revealed a large mass medial and anterior to the left kidney and contiguous with the left adrenal gland (Fig. 1).

TABLE 1

C. S. Laboratory Data.				
	Normal	5/79	6/79	8/79
VMA	6.8mg/24 hrs	24.7	30.1	4.8
FREE				
CCA	0-135µg/24 hrs		1764	73
CCA	0-275µg/24 hrs	2678	3345	236
META	0.9mg/24 hrs	12.8	13	0.78

VMA (Vanillylmandelic acid); FREE CCA (Free catecholamines); CCA (Total catecholamines); META (Metanephrines)

The patient was continued on prazosin 2 mg twice daily; he remained normotensive, asymptomatic and with a normal pulse throughout his preoperative period. Chlorthalidone was discontinued to prevent depletion of his blood volume. The last dose of prazosin was given the evening prior to surgery to allow his adrenergic system to regain its responsiveness.⁵ No other antihypertensive agents were used preoperatively. He underwent laparotomy on the 14th hospital day with removal of a 6x7 cm pheochromocytoma isolated to the left adrenal gland. Intraoperatively, significant hypertension was encountered with manipulation of the tumor. These episodes were easily managed with a drip of sodium nitroprusside

at a concentration of 50 mg in 500 cc of D5W titrated to maintain blood pressure at approximately 120/80 mm Hg. Hypotension developed with cross-clamping of the venous drainage from the tumor. This responded rapidly to volume expansion with normal saline. No arrhythmias or tachycardia developed during the course of the operation. Brief postoperative hypotension responded to infusion of normal saline. The remainder of the postoperative course was uneventful and he was discharged after one week, normotensive and in good condition. A follow-up 24-hour urine for VMA, metanephrines and catecholamines was found to be in the normal range (Table 1). A repeat glucose tolerance test was also normal. He remained symptom-free; he is mildly hypertensive but is controlled with diuretics.

Discussion

Heretofore, the alpha-adrenergic antagonists phenoxybenzamine hydrochloride and phentolamine have been the mainstays of therapy for the preoperative and intraoperative management of pheochromocytomas. Recently, Wallace and Gill¹ reported the use of the anti-hypertensive agent prazosin in the preoperative period of a patient with a pheochromocytoma. As in their case, our patient remained normotensive on therapeutic doses.

Prazosin has been shown to selectively inhibit the alpha-1 (postsynaptic) adrenergic receptors.^{8,9} This is in contrast to phentolamine and phenoxybenzamine which block both the alpha-2 (presynaptic) and alpha-1 receptors.⁹ Prazosin thus allows activation of the alpha-2 receptors which inhibit stimulus induced norepinephrine release. This mechanism is believed to be responsible for the lack of postural hypotension, tachycardia and renin release.⁹ These side effects are major problems with the older agents. The absence of these side effects may also be related to reduction in both arteriolar and venous tone, which prevent marked increases in venous return and cardiac output. Our patient suffered no adverse effects from prazosin and did not manifest a first-dose hypotension response. Thus, prazosin would appear to be an ideal drug for patients with pheochromocytomas based on its excellent sustained effectiveness in blood pressure control, simple twice daily oral dosage regimen, usefulness as both an inpatient and outpatient drug, and lack of significant side effects.

Angiography has been the main diagnostic tool in the localization of pheochromocytomas. However, there are significant risks with its use. It is an invasive procedure requiring contrast material and is frequently associated with hypertensive crises.⁴ The technically easier computerized tomography of the abdomen permits rapid, noninvasive and accurate localization of

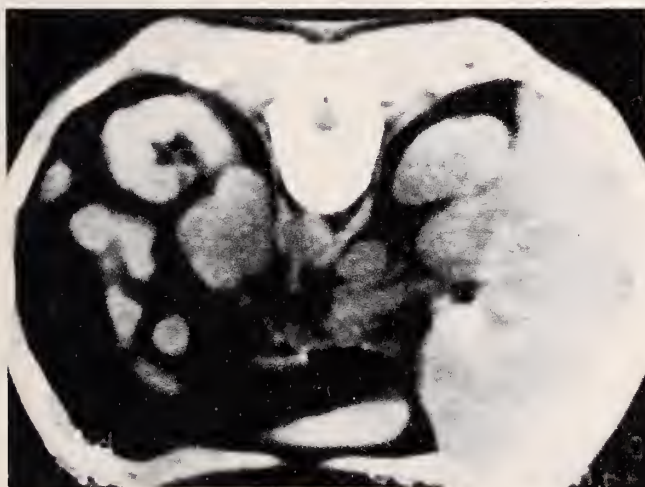


Fig. 1 — Computerized tomographic scan of abdomen showing mass medial and anterior to left kidney.

this tumor without these risks. The need for the use of contrast material in computerized tomography of the abdomen is rare in the localization of pheochromocytomas. It has been found to be at least as accurate as angiography with the ability to resolve tumors to a diameter of 2 cm.² It is useful in the localization of intradrenal and extraadrenal tumors. Combined with urine determinations of VMA, metanephrines and catecholamines, it is highly accurate and there is little indication to resort to invasive tests.

Sodium nitroprusside is a potent, rapidly-acting vasodilator particularly suited to the management of acute hypertensive crisis of various etiologies. Its use in

the intraoperative management of pheochromocytoma is well supported.^{6,7} Regardless of the preoperative alpha-blocking agent used, marked intraoperative fluctuations in blood pressure are observed with tumor manipulation. One of the major disadvantages of phentolamine is tachyphylaxis. Continued administration of the drug to control the blood pressure can result in unmanageable postoperative hypotension.⁵ Abrupt rises in blood pressure are easily and rapidly controlled with sodium nitroprusside. Hypotension encountered with sodium nitroprusside responds to reduction or discontinuation of the drug, and to volume expansion. Sodium nitroprusside is therefore an ideal drug for managing the vasomotor paroxysms found in pheochromocytomas.

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Alternatives to the Total Knee:

Current Status of Corrective Surgery of the Knee Without the Use of Implants

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Abstract: While total knee replacement remains necessary in late and severe cases, most knee imbalances caused by degenerative joint disease can be corrected by a judicious combination of osteotomies and realignment techniques. These are safer, effective, do not burn any bridges, and still leave the door open to total knee replacement, should this become necessary later on. State-of-the-art indications and techniques are reviewed.

The development of total knee replacement may have given the impression that this technique has become the definitive answer to degenerative diseases of the knee resulting in deformities and malfunction. There are, however, safer and more conservative techniques of arthroplasty requiring no implant, which have been developed in the past and continue to be developed. Significant new break-throughs are still being found.

1. Coventry's High Tibial Osteotomy for Unicompartmental Degenerative Disease (Fig. 1).

Wear of the knee joint usually starts in one compartment, most commonly the medial. Loss of height in this compartment results in a varus deformity of the knee, in which the line of force going from the hip to the ankle eventually passes medial to the knee joint. This leads to an uneven distribution of forces in the knee joint, with the lateral compartment being now placed in distraction, while the medial compartment is overloaded and rapidly degenerates, thus causing additional deformity.

The high tibial osteotomy described by Coventry¹ consists of subtracting a wedge of bone from the proximal portion of the tibia in order to realign the lines of force in the middle of the knee joint, or more preferably over the intact lateral condyle. This relieves the medial portion of the joint, and restores a normal force of distribution within the lateral portion of the joint now being placed back in compression.

The osteotomy also has a beneficial action on the bone congestion, alleviating the patient's pain.

Lateral degeneration of the knee, resulting in valgus deformity, may be corrected by a varus osteotomy but here the results are usually less satisfactory.

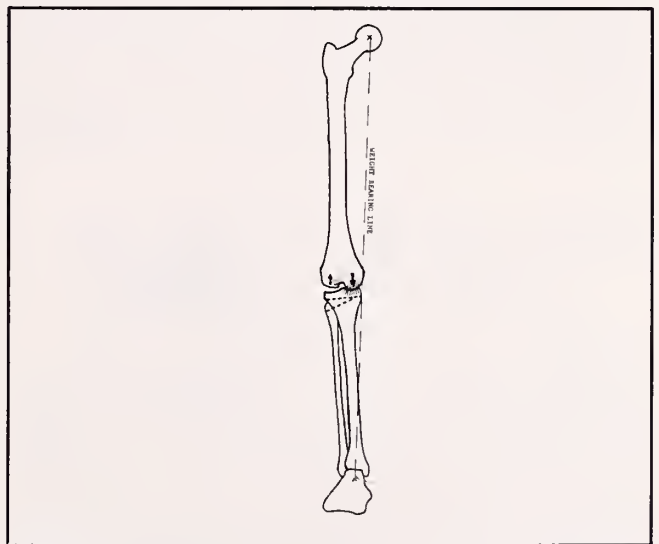


Fig. 1.

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2. The Patella Realignment Technique and the Excessive Lateral Pressure Syndrome (Fig. 2).

While the patellar ligament, extending from the tibial tubercle to the patella, is essentially vertical, the angle of action of the quadriceps muscle (Q angle) on the patella is somewhat laterally directed, essentially following the obliquity of the femoral shaft. This results in a component force pushing the lateral facet of the patella against the lateral condyle, which leads to early degenerative changes in this area. Tangential x-rays of the patella will show wear of the lateral half of the patello-femoral joint cartilage and thickening of the subchondral bone. This condition has been described by Ficat² by the excessive lateral pressure syndrome. It is often associated with a tightening of the lateral ligaments of the kneecap, further increasing the pressure on the lateral half of the joint; it may be alleviated by procedures similar to those used in correcting the lateral subluxation of the patella. These procedures consist of releasing entirely all ligaments on the lateral side of the patella complex, including the insertion of the vastus lateralis on the patella. If necessary, reefing of the medial ligaments may be performed. This procedure, however, may not be sufficient, and it may be indicated to transfer the patellar ligament³ or the tibial tubercle medially in order to place the patellar ligament in line with the lines of force from the quadriceps. Hauser⁴ detached the tibial tuberosity and reimplanted it in a hole placed more medially. The procedure was fraught with complications and was found to increase the pressure of the patella on the femur since the transplanted tibial tuberosity is often closer to the center of the bone than initially. Other techniques were then devised by Elmslie⁵, Goutallier⁶, Debeyre and Lord⁷, who detached only the superior portion of the tuberosity, and slid it medially, maintaining it in this new position with a screw or other fixation.

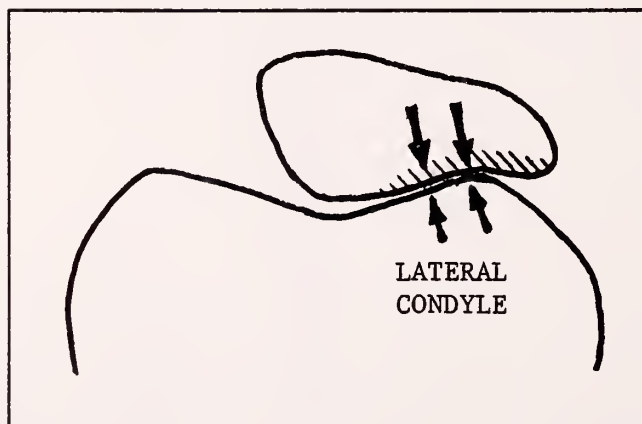


Fig. 2b.

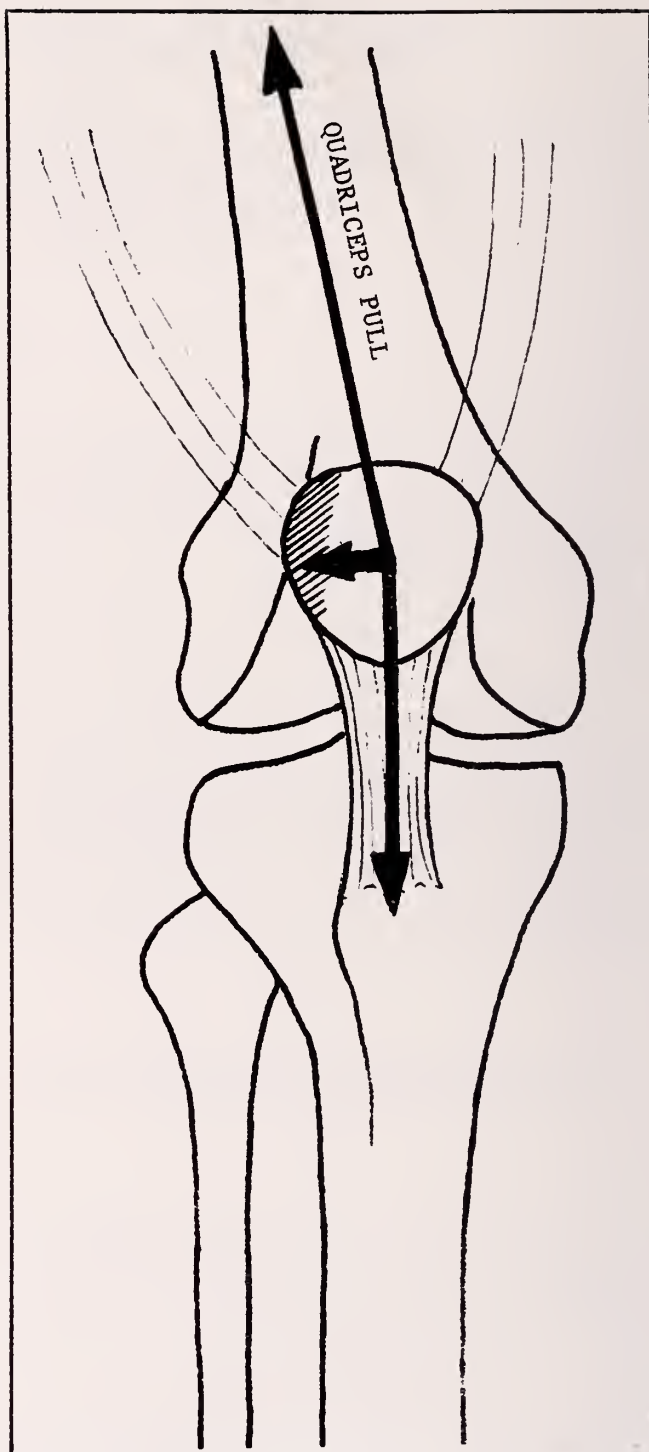


Fig. 2a.

Associated with these procedures, attempts were made to rejuvenate the cartilage of the patella by shaving off the degenerated area and/or perforating the subchondral bone to enhance the formation of new fibrocartilage. This maneuver provides fibrocartilage of poor mechanical quality, and its indications are limited.

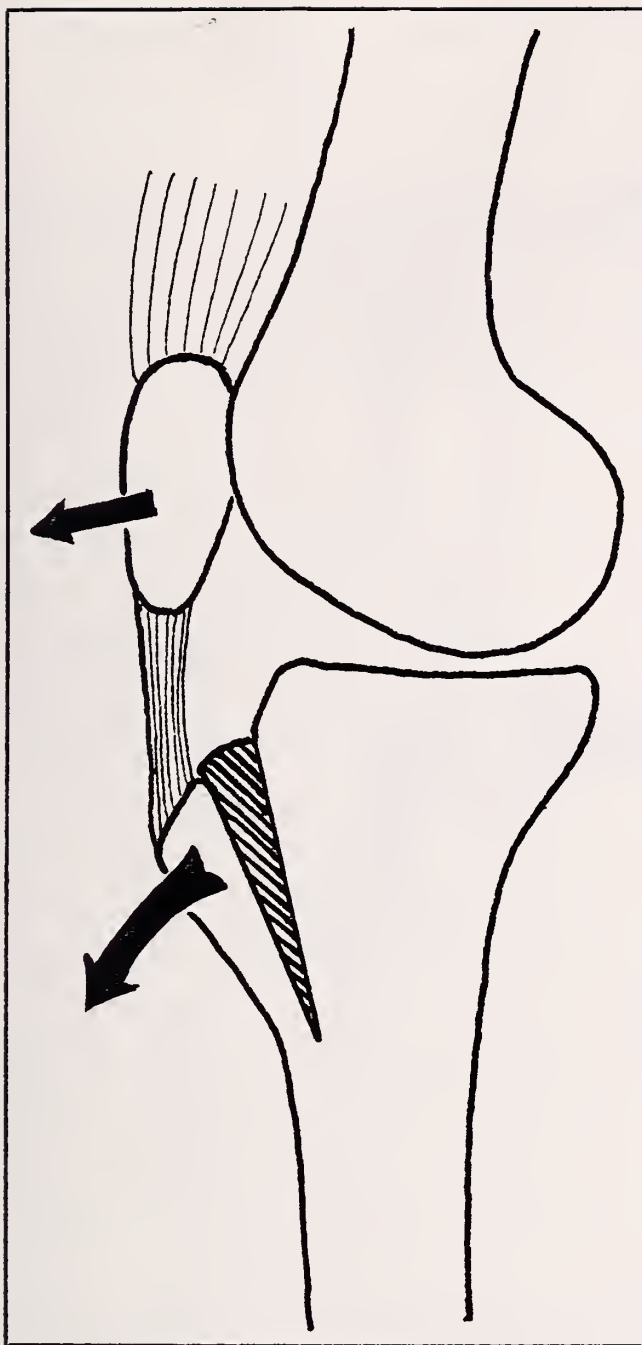


Fig. 3.

3. The Maquet Procedure and the Global Patello-Femoral Arthrosis (Fig. 3).

More recently, Maquet applied to the knee the reasoning and techniques previously applied by Pauwels to the hip. Very meticulous biomechanical calculations⁸ and experimentations⁹ led to the current procedure, which consists of splitting the tibial tubercle from the shaft and elevating it anteriorly with a bone block. The patella is also released laterally as previously described. It has been calculated that an elevation of 1 cm. reduces the patello-femoral pressure by 33%, and 2 cm. by 50%.¹⁰

This operation accomplishes four goals:

- It elevates the patella from the condyle, especially in extension.
- It redistributes the facet pressure more proximally in flexion.
- It increases the lever arm of the quadriceps ligament, thus reducing the necessity of heavy contraction, and reducing the patello-femoral pressure under load.
- It realizes a slight distal and medial realignment of the patella, which can be increased at the operator's will.

The Maquet procedure is a deceptively simple operation. The circulation in the tibial tubercle area is precarious, and a high percentage of complications will be encountered if great attention is not paid to preserving the blood supply. There is no place here for overenthusiastic dissection, and the exposure should be kept to a minimum.

4. The Combined Coventry-Maquet Procedure and the Medial/Patellar Syndrome (Fig. 4).

When the medial compartment and the patello-femoral joint are involved, which is commonly the case, it becomes possible to correct both conditions in one operation.¹¹ No additional incision for donor site is needed, as the bone removed in the osteotomy is used to supplement the other. All lines of force are rebalanced. This procedure is technically demanding, but if correctly executed, the morbidity is low.

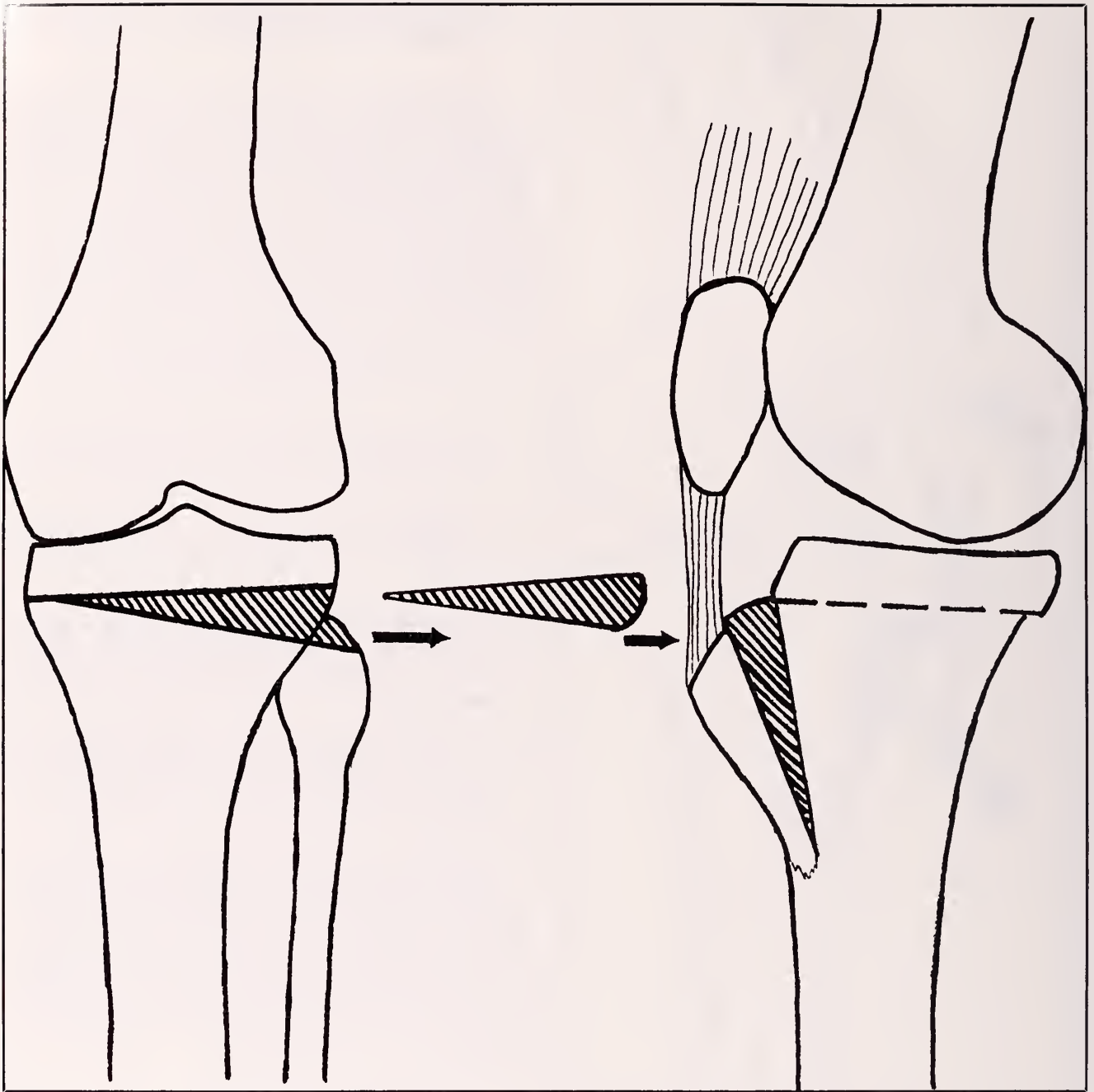


Fig. 4.

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The Type and Screen: It's Here to Stay

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Abstract: The backbone of pretransfusion compatibility testing has been and remains the major crossmatch. However, this procedure places pressure on already limited blood bank inventories because of the necessity of reserving units of blood for the exclusive use of one patient for up to 48 hours. The type and screen program has enabled transfusion services to better allocate their resources while still maintaining adequate reserves to meet all contingencies.

The use of the type and screen in a large acute care hospital is discussed along with data confirming its efficacy in providing blood without prior crossmatching for a variety of surgical procedures.

It has been a time honored tradition in blood bank laboratories to perform a crossmatch between the donor and recipient prior to transfusion. This has been done to insure compatibility of the transfused unit of blood¹; however, the crossmatch procedure results in the removal from the available blood bank inventory those units which have been crossmatched and therefore reserved for a specific patient. This blood is unavailable for infusion into other patients for a period of 24 to 48 hours, and during part of this time the units may be stored in an operating room refrigerator, physically removed from the blood bank. In view of the limited national blood supply, the increasing demand for blood and blood products, and the constraints placed on the blood bank inventory by the necessity of reserving units for the exclusive use of one patient,² it is apparent that a more efficient method of compatibility testing and blood allocation is desirable.

The development of the type and screen was prompted by the observation that, in many instances, blood that was crossmatched for a specific patient was, in fact, never transfused into that patient. This often occurs in surgical procedures where traditionally two units are requested for an operation that very rarely necessitates a transfusion.² The crossmatch to transfusion (C/T) ratio was developed as a numerical expression of the number of crossmatches that do not result in a transfusion. This ratio is often determined in the audit procedure carried out in hospitals to study the status of blood ordered for certain surgical procedures and medical conditions. Ideally the C/T ratio should be 1.0, but in

reality a C/T ratio of 2.1-2.7 is the lowest that is usually achieved. This means that approximately 2.5 times more blood must be kept in the blood bank than is transfused.³ The lower the C/T ratio the less blood will be held in the blood bank, unavailable for transfusion to the general hospital population.

The type and screen consists of an ABO grouping and Rh typing of the recipient as well as testing the recipient's serum for antibodies against the most common and clinically significant red cell antigens. If no antibodies are detected the blood bank assures that an adequate supply of ABO and Rh specific blood is on hand in case the need for transfusion arises. If an antibody is detected, the attending physician is immediately notified and the blood bank laboratory either crossmatches two units of compatible blood or finds units lacking the antigen against which the recipient has formed an antibody. Which of these two courses is followed depends on the anticipated need for blood as determined by the clinician.

It has been confirmed by investigators that the type and screen will detect 96% to 97% of antibodies in the recipient's serum.³ However, when both antibody and antigen frequencies are taken into consideration, studies have shown that the type and screen is 99.99% effective in the prevention of an incompatible transfusion.^{2 3}

The type and screen is appropriate for those surgical and obstetrical procedures which average less than 0.5 units transfused per operation.³

In our institution we have found that those procedures listed in Table 1 necessitate only a type and screen. This list, which represents only a fraction of the procedures for which a type and screen is performed, was formulated by the Chiefs of Services in consultation with the Medical Director of the Transfusion Service.

The Authors

ROBERT L. HELLMAN, M.D. AND THOMAS A. NOTO, M.D.

Dr. Hellman is Assistant Professor of Pathology and Associate Director of the Transfusion Service, and Dr. Noto is Professor of Pathology and Medical Director of the Transfusion Service, University of Miami/Jackson Memorial Medical Center, Miami.

When an antibody is discovered during the type and screen, compatible blood is made available should the need arise. In an emergency the units are released after reconfirmation of their compatibility with the recipient's serum. This is accomplished by performing an abbreviated crossmatch which takes five minutes and is done to guard against the potentially devastating consequences of the transfusion of ABO incompatible blood.¹ The full crossmatch, which takes an additional 30 minutes, is then completed while the blood is being administered to the patient. The physician ordering blood during an emergency may be confident that no untoward reactions are likely to occur, because the recipient has either been previously shown not to have any red cell antibodies, or if an antibody was detected, the recipient is receiving blood which does not contain the corresponding antigen. The Medical Director of the blood bank assumes full responsibility for the incomplete crossmatch and signs the release form for uncrossmatched blood.

It has been our experience that the type and screen is an effective alternative to the crossmatch in patients who do not have a great probability of receiving blood. In our institution and others⁴ this is often the case in women

who are candidates for an uncomplicated or scheduled repeat Cesarean section. The type and screen program has been successful in providing safe compatible blood while simultaneously resulting in improved blood inventory control. Since October 1978, we have performed approximately 37,000 type and screen procedures. Only in two cases (0.006%) have antibodies been detected during the type and screen. These were weak reacting antibodies of limited clinical significance. Even in the emergency room selected patients, such as those with mild vaginal bleeding, soft tissue infections and superficial trauma who previously may have had a two unit crossmatch performed have also benefited from the type and screen program.

There is a tentative movement nationally to abbreviate pretransfusion compatibility testing by eliminating the majority of the crossmatch procedure, because 98 to 99 percent of the population is free of serum red cell antibodies other than anti A, anti B, and anti D⁵. Reliance is placed on the type and screen with reconfirmation of ABO compatibility prior to release of the blood. This results in lower costs to the patient and better use of a limited resource, while providing a safe product for transfusion. Acceptance of this change in compatibility testing is currently very limited and confirmation of its efficacy will await further large scale clinical studies. The future, however, will probably see at least a variation of this modification in transfusion practice as the pressure on blood inventories and hospital costs increases.

References

1. Oberman, H.A.; Barnes, B.A. and Friedman, B.A.: The Risk of Abbreviating the Major Crossmatch in Urgent or Massive Transfusion. *Transfusion* 18:137-141, 1978.
2. Boyd, P.R.; Skeedy, K.C. and Henry, J.B.: Type and Screen: Use and effectiveness in elective surgery. *Am. J. Clin. Pathol.* 73:694-699, 1980.
3. Boral, L.I. and Henry, J.B.: The Type and Screen: A Safe Alternative and Supplement in Selected Surgical Procedures. *Transfusion* 17:163-168, 1977.
4. Friedman, B.A.: An Analysis of Surgical Blood Use in United States Hospitals with Application to the Maximum Blood Order Schedule. *Transfusion* 19:268-278, 1979.
5. Issitt, P.D.: Antibodies Reactive at 30 Centigrade, Room Temperature, and Below in "Clinically Significant and Insignificant Antibodies". Washington, D.C. American Association of Blood Banks, p. 13, 1979.

● Dr. Hellman, 1611 N.W. 12th Avenue, Miami 33136.

**Table 1. —
Procedures for Which a Type and Screen is Utilized.
General Surgery**

Breast biopsy
Cholecystectomy
Hernia repair
Mastectomy, simple and radical
Splenectomy
Tracheostomy
Vein stripping

Gynecology

Cone biopsy of cervix
D & C
Hysterectomy
Tubal ligation

Obstetrics

Breech presentation
Uncomplicated Cesarean section
Repeat Cesarean section, scheduled
Low forceps delivery and episiotomy

Orthopedic Surgery

Leg amputation

Urology

TUR prostate
TUR bladder tumor



SPECIAL ARTICLE

The 1982 Florida Relative Value Studies

Joel W. Mattison, M.D.

The 1982 *Florida Relative Value Studies* is scheduled for distribution to Florida Medical Association members in March.

A Relative Value Study (RVS), by way of a working definition, is an attempt to relate all medical services and surgical procedures one to another on a scale of comparative value. It also follows, for those who wish to do so, that these services and procedures can be related to some form of absolute (through a conversion factor), giving some idea of their relative worth.

Since not all patients and not all procedures are alike, there are necessarily provisions that must be made for extenuating circumstances in a small number of cases. This is recognized by assigning a different value for such services or procedures as, for example, brief office visits as compared with extended office visits, and small lesions removed as compared with large lesions removed. In general, however, it is postulated that the range of difficulty for more common services or procedures will average out, the simple ones compensating for the more complex ones, so that a physician, while he may never do an average procedure on an average patient, may nevertheless generally feel that the average fee for a given service or procedure might well be calculable.

One of the important aspects of a Relative Value Study or system is that it gives us a common vocabulary with which to communicate informatively with third-party payer computers. Like it or not, we are now in a computer age with lay persons, untrained in medicine, operating the machines. It follows that they are usually not competent or trained to make decisions about exactly what procedure was performed or service rendered. It is our privilege and responsibility to provide that vocabulary by which the computer is informed properly of what

we as physicians have done for a particular patient. This is not an endorsement of the computer system but rather a recognition of its inevitability and permanent status.

Reasons for the New RVS

The 1975 *Florida Relative Value Studies* (the current orange edition) is being updated by the Florida Medical Association for at least four reasons:

First, there are many new procedures for which new codes have been assigned (since 1975), as medical and surgical progress marches on.

Second, our *Florida Relative Value Studies* needs to be standardized with the American Medical Association's *Current Procedural Terminology Fourth Edition* (CPT-4) — a uniform and universal system of nomenclature devised by physicians to reflect accurately the level and complexity of medical services and surgical procedures. Much of the language of our present (1975) study was based upon what is now CPT-4, but by no means all of it. This uniformity resulting from the 1982 Florida update using CPT-4 codes and descriptors will be an invaluable aid in allowing the entire United States to be on the same basic uniform language system, consisting of 5-digit code numbers identifying standard descriptors.

Third, although ideally relativity should not change, it may well do so since all things change, as Heraclitus observed in the Fifth Century B.C. Furthermore, the 1975 study was arrived at by surveying Florida physicians regarding important and frequent services and procedures; the rest of the relativity was of necessity arrived at by statistically interpolating. A broader statistical base of all procedures would be preferable.

Fourth, some procedures previously designated "RNE" (relativity not established) have now enough statistical data to be assigned a valid relative value.

The Committee's Charge

The five-member Committee on Relative Value Studies was charged with updating the Florida RVS using CPT-4 and reporting the charge patterns of Florida

The Author

JOEL W. MATTISON, M.D.

Dr. Mattison is Chairman of the Florida Medical Association Committee on Relative Value Studies. Professionally, he is a Plastic and Reconstructive Surgeon in Tampa.

physicians as statistically observed and as accurately as possible.

Each portion of this charge had implications. Use of CPT-4 means that it must not only be used for convenience, but it must be strictly followed as well. We must use the 5-digit codes and descriptors as approved by the AMA designated committee — without alteration. We cannot clarify, make more logical, render fairer, alter the wording, or add codes or descriptors, even those which on reasonable authority will likely be approved soon.

Reporting the charge patterns means that we can only observe and report objectively what is currently being done in Florida insofar as can be ascertained with a reasonable degree of accuracy. We are not empowered to be judges, legislators, nor are we to correct or, in any way, to alter our findings. We can of course question and verify, but, once verified, the findings must be reported and let stand. Only with a totally objective Committee, guided by an accurate and reliable statistician, can the book have any true value and acceptance. It is hoped that this objectivity will not be interpreted as deafness or callousness by our colleagues.

The Florida Medical Association has afforded the Committee the pleasurable necessity of having a statistician to help us to understand what we observe and to help us to question and investigate findings that do not seem on the surface to be accurate. Although we cannot right seeming wrongs, we can be certain that we have asked the right questions and properly interpreted the results and that the statistics have not been inaccurately compiled. To this end, we are identifying by a computer study all procedures and services significantly different in 1982 from those in 1975; these will receive close scrutiny.

Large Statistical Base

We have had the opportunity of having a statistical base of some 30 million *charges* on which to develop our study. The Blue Shield computers in Jacksonville have this massive collection of data and we have been able to work with their data processors to analyze these *charges*. (*Charges* has been italicized to emphasize its distinction from *allowances*).

Before utilizing these data, we had first to satisfy ourselves by establishing two facts: (1) Could we accurately separate out the physician's *charges* from the Blue Shield *allowances*? Our independent statistical consultant verified that we could. (2) Could we verify the accuracy of the Blue Shield data? Again we must emphasize that we hired an independent consultant — a man of national reputation, of unimpeachable integrity, and experienced in working with our Committee in the past. We could trust him, we could work with him, and we could understand him. He has sat in on our every session and has worked with the Blue Shield statisticians many hours between our sessions. We have satisfied ourselves that the data are accurate, and with his help, we have asked many more questions than our limited knowledge would have led us to do.

The instrument to be delivered to FMA members in March will not be perfect; we are human beings, and the data we have analyzed and reported comes from human sources. We have sought assiduously to keep that error at its bare minimum.

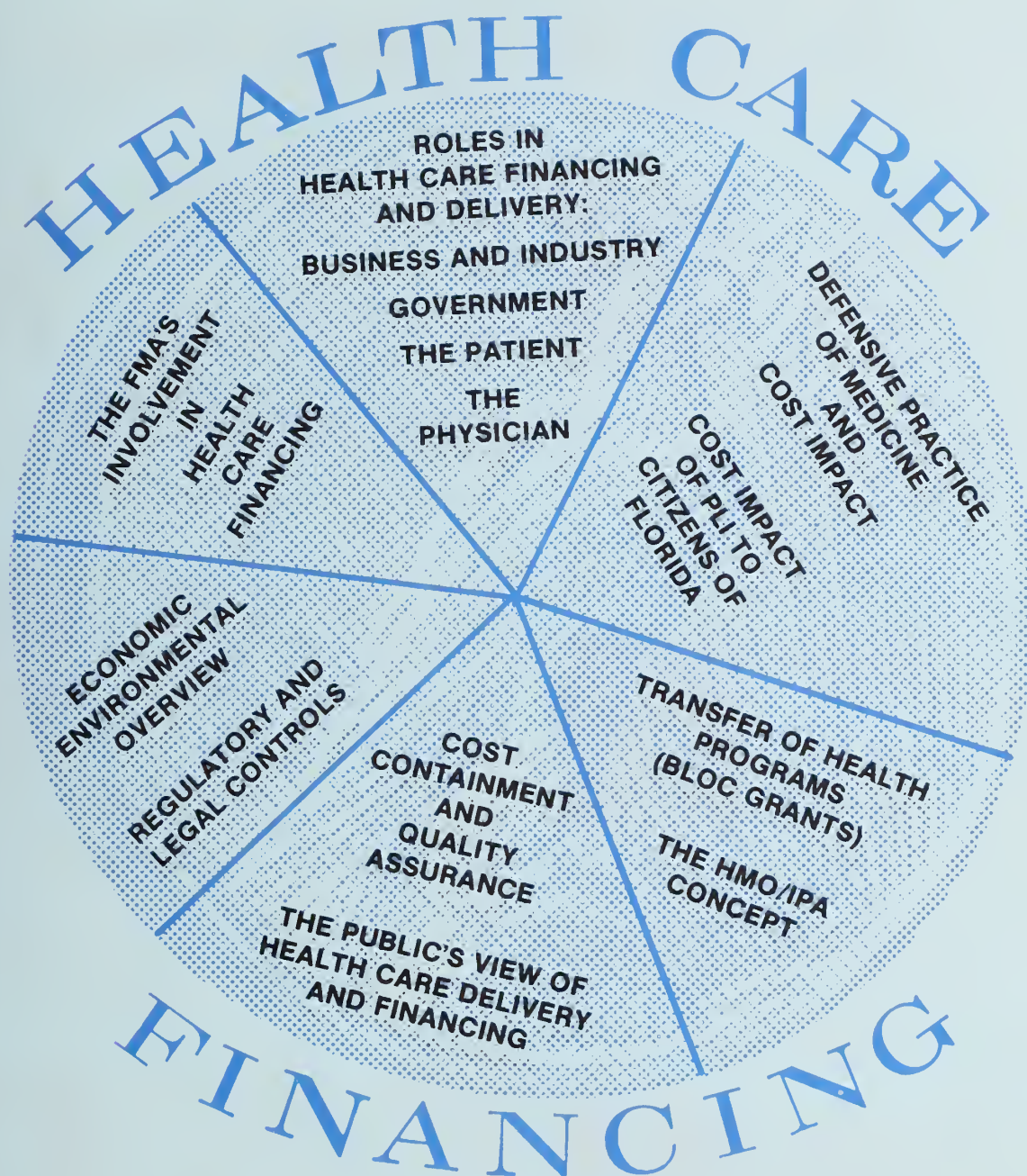
One of a Kind

The 1982 RVS will, however, be the only one of its kind in the United States. Other previous systems have been based either on smaller samplings or even committee decision on relativity. Ours will be broadly based and accurately verified.

We have sought the help of the Council on Specialty Medicine and have distributed our copy to them before typesetting for their proof reading, verification, and suggestions. Their help is vital to the usefulness of our finished product. A weekend session with the Council was held in Orlando on December 12, giving us broad representative input from the entire Association.

We are grateful to those members of the FMA who have met with our Committee and provided us with help. We hope that our efforts will make the practice of medicine easier by removing some of the difficulties from our daily routine. Our first duty, after all, is to heal or comfort the sick; if we can reduce the financial encumbrances to a minimum, then we can go about that primary task.

Announcing
**1982 FLORIDA MEDICAL ASSOCIATION, INC.
LEADERSHIP CONFERENCE**



**JANUARY 30 - 31, 1982
DUTCH INN, LAKE BUENA VISTA, FLORIDA**

Financing health and medical care is one of the most critical issues facing organized medicine as well as our citizens today. Consequently, Florida Medical Association President Sanford A. Mullen, M.D., has assembled a program on "Health Care Financing" composed of leading national experts to address various facets of this issue during the Association's annual Leadership Conference, January 30-31, 1982 at the Dutch Inn, Lake Buena Vista, Florida.

To cope with the challenges of the 80's, physicians must understand the current practice environment, the factors contributing to it, what direction to follow and how to get there if the private practice of medicine and quality patient care is to survive. Attendance at this Conference is vital for all of those in county society leadership positions; however, all FMA members are encouraged to attend.

A block of rooms has been reserved for the Conference at the Dutch Inn and reservations and registration information may be obtained by contacting the FMA Headquarters Office in Jacksonville, 904/356-1571. This pamphlet contains the program outline along with thumbnail sketches outlining the expertise of various speakers who will be appearing during the program.

PROGRAM

- 8:00 a.m. • Registration
- 9:00 a.m. • Presiding — Sanford A. Mullen, M.D., President
 - Introductory Remarks — Dr. Mullen
- 9:15 a.m. • Economic Environmental Overview — Eli Ginzberg, Ph.D., Director, Conservation of Human Resources, Columbia University, New York, New York
- 9:45 a.m. • Regulatory and Legal Controls — Gary J. Clarke, J.D., Deputy Assistant Secretary for Health Planning and Development, Department of Health and Rehabilitative Services, Tallahassee, Florida
- 10:15 a.m. • **REFRESHMENT BREAK**
- 10:30 a.m. • Cost Containment and Quality Assurance — Samuel B. Tibbits, Co-Chairman, National Voluntary Effort, Los Angeles, California
 - Defensive Practice of Medicine and Cost Impact — James S. Todd, M.D., Vice President, Physicians' Insurance Association of America, Ridgewood, New Jersey
 - Professional Liability Insurance — Cost Impact to Floridians — Vernon B. Astler, M.D., Chairman, Florida Physicians' Insurance Reciprocal
- 12:00 noon • **COMPLIMENTARY LUNCHEON** — The Pro-Competition Concept — U.S. Senator Dave Durenberger, R-Minn.
- 2:00 p.m. • Presiding — Robert E. Windom, M.D., President-Elect
 - Transfer of Health Programs (Bloc Grants) — State Representative Richard S. Hodes, M.D., Tampa, Florida
 - The FMA's Involvement in Health Care Financing — Charles P. Hayes Jr., M.D., Chairman, FMA Council on Health Care Financing
 - The HMO/IPA Concept — Mr. Stephen A. Doiron, Boca Raton, President and Chief Executive Officer of Caribbean Atlantic Resource Enterprises, Inc.
 - The Public's View of Health Care Delivery and Financing — Mr. Roy A. Pfautch, President, Civic Service, Inc., St. Louis, Missouri
- 6:30 p.m. • **COMPLIMENTARY RECEPTION**

Sunday — January 31, 1982

- 8:00 a.m. • Registration
- 9:00 a.m. • Presiding — Sanford A. Mullen, M.D., President
- 9:15 a.m. • Roles in Health Care Financing and Delivery
 - Government's Role — Edward N. Brandt Jr., M.D., Assistant Secretary for Health, Washington, D.C.
 - Business and Industry's Role — Mr. Robert A. Carpenter, Manager, Health Care Cost Containment, Republic Steel Corporation, Cleveland, Ohio
 - The Patient's Role — Miss Bess Myerson, Consumer Advocate, New York, New York
 - The Physician's Role — James H. Sammons, M.D., Executive Vice President, AMA, Chicago, Illinois
- 11:15 a.m. • Summation — Sanford A. Mullen, M.D., President
- 12:00 noon • **ADJOURNMENT**



SANFORD A. MULLEN, M.D., is the 105th President of the Florida Medical Association, Inc. One of his major goals as the leader of the 14,000 member physician organization is health care financing, which led to the theme for the 1982 Leadership Conference. Dr. Mullen is President of the Jacksonville Blood Bank, operates a private independent medical laboratory in Jacksonville, is Co-Chief of Pathology at University Hospital, Jacksonville, and is a clinical professor at the University of Florida.

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ELI GINZBERG, Ph.D., serves as Director, Conservation of Human Resources, Columbia University, New York, N.Y. His remarks will be on the economic environmental overview of health care financing. He is a member, Institute of Medicine, National Academy of Sciences, and Allen O. Whipple Society. He is a Fellow of the American Academy of Arts and Sciences and has received the Blue Cross/Blue Shield National Health Achievement Award in Health Economics.

* * *



GARY J. CLARKE, J.D., Assistant Secretary for Health Planning, Department of Health and Rehabilitative Services, Tallahassee, will address the subject of Regulatory and Legal Controls. In addition to his legal background, Mr. Clarke has served as Director of the Intergovernmental Health Policy Project at George Washington University, and as Editor of the health publication "State Health News". He has been published in numerous health journals and acted as a consultant to the National Association of State Mental Retardation Program Directors, and the National Conference of Governors.

* * *



MR. SAMUEL J. TIBBITS, Southern California, is a founder and Co-Chairman of the National Steering Committee for the Voluntary Effort to Contain Health Care Costs. Mr. Tibbits is recognized as an expert and innovator on cost containment and quality assurance. He is a pioneer in the development of the nonprofit, multi-hospital field. He holds a Fellowship in the American College of Hospital Administrators, has received the citation for Meritorious Service, Trustees Award, from the American Hospital Association and is listed in *Who's Who* in the world.

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JAMES S. TODD, M.D., Ridgewood, New Jersey, Vice President of the Physicians' Insurance Association of America, is a Diplomate of the American Board of Surgeons. He has served as an instructor in surgery at the Columbia Presbyterian Medical Center, New York, and was elected as a Trustee of the American Medical Association—1980. Among his published articles was "Second Opinion — No Substitute for Judgement" in the *Journal of the Medical Society of New Jersey* last year.

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VERNON B. ASTLER, M.D., Boynton Beach, is one of the founders and Chairman of the Board of the Florida Physicians' Insurance Reciprocal. Dr. Astler is a Past President of FMA, and of the Florida State Board of Medical Examiners. He serves as FMA's Public Relations Officer, is a Diplomate, American Board of Surgery and conducts an active practice in Boynton Beach, Fla. He served as a Captain, U.S. Army Medical Corps in Korea.

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DAVE DURENBERGER, U.S. Senator, R-Minn., is the second Republican Freshman Senator ever to serve on the Committee on Finance. He also is a member of the Senate Committee on Intelligence. He participates on subcommittees which include: Health, Energy, Revenue Sharing, Intergovernmental Relations and Oversight of Government Management. He was elected to the Senate in 1978 to fill the remaining four years of the term to which the late Hubert Humphrey had been elected.

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RICHARD S. HODES, M.D., Tampa, is currently Dean of the Florida House of Representatives and Chairman of the National Council of State Legislators. He has been in the private practice of Anesthesiology since 1951 and head of the Section on Anesthesiology at Tampa General Hospital since 1958. He is a Past President of the FMA as well as his state specialty society and serves as Treasurer of the Florida Physicians' Insurance Reciprocal.

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CHARLES P. HAYES JR., M.D., Jacksonville, is Chairman of FMA's Council on Health Care Financing. He is President-Elect of the Florida Society of Internal Medicine and a member of the Board of Directors and Executive Committee of Blue

Cross/Blue Shield of Florida. Dr. Hayes is a member of the International Society of Nephrology, a Fellow of the American College of Physicians and serves as Medical Director, Dialysis Clinics of Jacksonville, Inc.

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MR. STEPHEN A. DOIRON, Boca Raton, is President and Chief Executive Officer of Caribbean Atlantic Resource Enterprises, Inc. He has under his jurisdiction the parent organization and four wholly owned subsidiaries. These

include Florida Atlantic Resources, Inc., which provides marketing information and technological advice to the insurance industry along with Health Care Finance Associates, a company furnishing broad technical assistance to evolving and operational health plans, including evaluation and technical guidance to HMO/IPA plans. Lifestyle Incentives and Fitness Enterprises, Inc., provides wellness training and fitness measurements to subscribing groups and the National Health Issues Forum seeks to direct dispassionate discussions on solutions to health care problems.

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MR. ROY PFAUTCH, President of Civic Services, Inc., St. Louis, Missouri, is recognized as one of the most reliable sensors of public opinion in America. His firm's "Mood of America" survey has been termed as the "most reliable"

of the national soundings of American thinking. His expertise as a political consultant is best recognized by his peers who elected him President this year of the American Association of Political Consultants. He is also a member of the Council on Public Polls, the American Association for Public Opinion Research and the Marketing Research Association.

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EDWARD N. BRANDT JR., M.D., Washington, D.C., is Assistant Secretary for Health, Department of Health and Human Services. In that position he provides policy guidance for other HHS health programs including the

Health Care Financing Administration, which administers Medicare and Medicaid. He also maintains relation-

ships with other governmental and private agencies concerned with health. Long active in organized medicine at the time of his appointment, Dr. Brandt was serving as Chairman of AMA's section on medical schools.

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MR. ROBERT A. CARPENTER, Cleveland, Ohio, is Manager of Health Care Cost Containment for Republic Steel Corporation and is also President of the Board of Directors of the National Association of Employers on Health Care

Alternatives (NAEHCA). Mr. Carpenter is a company representative to the Washington Business Group on Health and a charter member of the Board of Directors of the greater Cleveland Coalition on Health Care Cost Effectiveness. He is also a member of the Cook County Private Utilization Review Coordinating Council.

* * *



MISS BESS MYERSON, New York City, ranks among the leading achievers in America, particularly for her poise and beauty as Miss America and as the first Commissioner of Consumer Affairs for New York City. She initiated and devel-

oped successful legislative, educational and information programs which have since been adopted as guidelines for consumer offices throughout the country. Her nationally-syndicated newspaper column, "Listen, Bess," was a popular coast-to-coast forum for readers' frustrations on social, economic, urban and political problems. She has also served on three Presidential Commissions.

* * *



JAMES H. SAMMONS, M.D., Chicago, Illinois, is Executive Vice President of and chief spokesman for the American Medical Association. A practicing physician prior to assuming his current position, Dr. Sammons is eminently qualified to

reflect the role of his colleagues. A native of Alabama, Dr. Sammons interned in Mobile and began his practice in Texas. In addition to having served as President of the Texas Medical Association, on various AMA committees and councils, he is also a member of the Advisory Council of the Graduate School of Management, Northwestern University.

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NOTES AND NEWS

44 Florida Hospitals Await JCAH Surveys

The Joint Commission on Accreditation of Hospitals (JCAH) will conduct accreditation surveys of 44 hospitals in Florida during the first three months of 1982. JCAH identified them as:

Bethesda Memorial, Boynton Beach; Lykes Memorial, Brooksville; South Lake Memorial, Clermont; Community General, Dade City; Halifax Hospital Medical Center, Daytona Beach; Waterman Memorial, Eustis; Lawnwood Medical Center, Fort Pierce; and Doctors Hospital, Hollywood Medical Center, and Memorial, all of Hollywood.

Jacksonville General and University Hospital, both of Jacksonville; Community, Kissimmee; John F. Kennedy Memorial, Lake Worth; A. G. Holley, Lantana; Leesburg General, Leesburg; and American Hospital, Coral Reef General, International, Jackson Memorial, Mercy, North Shore Medical Center, Pan American, University of Miami Hospitals and Clinics, and Victoria, all of Miami.

West Pasco, New Port Richey; Munroe Memorial, Ocala; Opa Locka Carol City Community Hospital, Opa Locka; Florida Hospital, Orlando; Memorial, Ormond Beach; Palm Beach Gardens Community, Palm Beach Gardens; Medical Center, Punta Gorda; Seminole Memorial, Sanford; University General, Seminole; Larkin and South Miami, South Miami; and Flagler, St. Augustine.

Bayfront Medical Center and All Childrens, both of St. Petersburg; Martin Memorial, Stuart; Centro Asturiano and U.S. Air Force Regional Hospital, both of Tampa; Hardee Memorial, Wauchula; and Winter Haven Hospital, Winter Haven.

FPIR Chairman Addresses National Medical Forum

Vernon B. Astler, M.D., Chairman of the Florida Physicians' Insurance Reciprocal (FPIR), addressed the national Forum for Medical Affairs last month on the subject of "Physician-Owned Insurance Companies: Are They Viable?"

The half-day program, devoted to "Malpractice Update" was held on December 6, 1981, at Las Vegas,

Nev., in conjunction with the mid-year meeting of the House of Delegates of the American Medical Association.

The Forum for Medical Affairs meets annually to examine important issues facing the medical profession. It is composed of presidents, presidents elect and executive directors of state medical associations, state medical association journal editors and representatives of medical specialty societies.

Dr. Astler, a resident of Boynton Beach, Fla., is a Past President of the Florida Medical Association and of the Florida State Board of Medical Examiners. He has been active in the management of FPIR since it was organized a few years ago.

Directors Named For Foundation Emergency Medical Service Study

Two North Florida physicians have been appointed to direct a Florida Medical Foundation study of Florida's emergency medical service capabilities.

The program is being conducted under a \$300,000 grant authorized by the Florida Legislature in 1981. The Florida Department of Health and Rehabilitative Services picked the Foundation, a subsidiary of the Florida Medical Association, to conduct the investigation.

Raymond H. Alexander, M.D., of Gainesville, was named Medical Director. Peter T. Pons, M.D., of Jacksonville, will serve as his assistant. The FMA Committee on Emergency Medical Services will serve as the steering committee.

Objectives of the program will be: to analyze the capabilities of the State's critical care facilities; to produce a report describing the status of emergency medical services in the State; to develop a five-year plan identifying reasonable goals and objectives for improving the delivery of emergency care; and to provide medical direction for the State EMS Program.

**MARK YOUR CALENDARS
FOR FMA ANNUAL MEETING
MAY 5-9, 1982**

3 More Annual Meeting Programs Are Announced

Three additional scientific section programs for the 108th Annual Meeting of the Florida Medical Association have been announced.

According to Calvin W. Martin, M.D., of Arcadia, Vice Chairman of the FMA Committee on Medical Education in charge of the Annual Meeting Scientific Program, plans are complete for the Sections on Physical Medicine and Rehabilitation, Neurology and Nuclear Medicine, and Pediatric Cardiology. All three will be conducted on Saturday morning, May 8.

The Annual Meeting will get under way on Wednesday, May 5, at Hollywood's Diplomat Hotel. The convention will finish up on Sunday, May 9.

SECTION ON NEUROLOGY AND NUCLEAR MEDICINE

(Co-sponsored by Florida Society of Neurology and Florida Society of Nuclear Physicians)

Saturday, May 8 — 9:00 a.m. to 12:00 noon

Warren R. Janowitz, M.D., Miami Beach

Steven A. Shaivitz, M.D., West Palm Beach

Program Chairmen

"Introduction: New Techniques in Imaging, Positron Emission Tomography, Nuclear Magnetic Resonance and High-Resolution Real-Time Ultrasound" — Warren R. Janowitz, M.D., Assistant Professor of Radiology, University of Miami School of Medicine, Mount Sinai Medical Center, Miami Beach.

"Positron Emission Tomography: Basic Instrumentation and Radiopharmaceuticals" — Peter Kenny, Ph.D., Professor of Radiology, University of Miami School of Medicine, Mount Sinai Medical Center, Miami Beach.

"Neurological Investigation with PET" — Myron Ginsberg, M.D., Department of Neurology, University of Miami School of Medicine, Miami.

"Potential Neurosurgical Applications of PET" — Ross Davis, M.D., Director of Neurological Surgery, Mount Sinai Medical Center, Miami Beach.

"Nuclear Magnetic Resonance (NMR) Imaging: Current Status" — Aldo N. Serafini, M.D., Director, Division of Nuclear Medicine, University of Miami School of Medicine, Miami.

"Non-invasive Carotid Evaluation by Doppler and Real-Time Ultrasound" — Warren R. Janowitz, M.D., Miami Beach.

"Neurosurgery: Malpractice Claims Experience" — Mr. John Robinson, Vice President for Claims, Professional Insurance Management Company (PIMCO), Jacksonville.

SECTION ON PEDIATRIC CARDIOLOGY

(Co-sponsored by Florida Association of Pediatric Cardiologists)

Saturday, May 8 — 8:30 a.m. to 11:00 a.m.

Arthur S. Pickoff, M.D.

Program Chairman

"Developmental Changes in the Biochemistry of the Aorta" — Robert Boucek, M.D., Professor of Medicine and Director, Division of Gerontology, Department of Medicine, University of Miami School of Medicine, Miami.

"Developmental Aspects of Atherosclerosis: A Pediatric Perspective" — Mary Jane Jesse, M.D., Professor and Vice Chairman, Department of Pediatrics, University of Miami School of Medicine, Miami.

"Changes in Cardiac Electrophysiology with Age" — Alan Ezrin, Ph.D., Research Associate Fellow, Department of Pharmacology and Pediatrics, University of Miami School of Medicine, Miami.

"Process of Aging as it Relates to the Pharmacologic Management of Cardiovascular Disorders" — Sharanjeet Singh, M.D., Visiting Assistant Professor, Department of Pediatrics (Cardiology) and Pharmacology, University of Miami School of Medicine.

SECTION ON PHYSICAL MEDICINE AND REHABILITATION

(Co-sponsored by Florida Society of Physical Medicine and Rehabilitation)

Saturday, May 8 — 9:00 a.m. to 11:00 a.m.

Solomon Winokur, M.D., Lake Worth

Program Chairman

"Evoked Somato-Sensory Potentials in Physical Medicine and Rehabilitation" — W. T. Liebersohn, M.D., Ph.D., Brooklyn, N.Y.

Florida Medical Leaders To Visit Mainland China

A delegation of medical and health leaders in Florida plans to visit the People's Republic of China this summer.

According to Carl L. Brumback, M.D., of West Palm Beach, who is arranging the trip, the group will leave on May 31 and visit medical leaders and medical facilities and inspect medical services in various parts of China.

Florida physicians and their spouses who are interested in making the trip should contact Dr. Brumback for additional information. His address is: P. O. Box 29, West Palm Beach, Fla. 33402, telephones: (305) 837-3119 (office), and (305) 585-0389 (home).

Association Qualifies For Eighth AMA Delegate

The Florida Medical Association has been advised that because of American Medical Association membership gains in the State, FMA will be entitled to an additional representative in the AMA House of Delegates this year.

This will bring to eight the strength of FMA in the AMA House. There are also eight alternate delegates.

AMA House of Delegates representation is apportioned on the basis of one Delegate for each 1,000 AMA members or fraction of a thousand. Florida's AMA membership at the time delegate strength is computed was 6,380 dues paid members and 1,031 dues exempt members, for a total of 7,411.

The eighth Delegate and eighth Alternate Delegate will be elected during the 108th Annual Meeting of FMA next May. Those elected will serve a two-year term retroactive to January 1, 1982 and will serve at the 1982 Annual Meeting of AMA, which will be in Chicago, June 13-17.

The Up With People Show Tours Florida for Ronald McDonald Houses

The all new 1982 edition of the Up With People Show is slated for a month-long tour of Florida beginning January 29.

Net proceeds will go to support the Ronald McDonald House locations in Gainesville, St. Petersburg and Miami.

Preceding the two-hour public shows in each city, the casts will spend up to five days performing at area schools, hospitals, nursing homes and other institutions.

Incorporated in 1968 as a nonprofit, independent, educational program, Up With People has a two-fold purpose: to build bridges of understanding and communication among peoples, cultures and countries; and to give young people a learning experience that not only broadens the intellect, but matures the person.

Ronald McDonald Houses, a nonprofit corporation, are owned and operated by an organization comprised of parents, hospital and medical personnel and community volunteers.

For more information on Up With People's 1982 Florida State Tour to benefit Ronald McDonald House, call Sharon M. Thompson, (904) 673-3700.

FMA Announces Medical Journalism Awards Contest

The Florida Medical Association is now accepting entries in its 1982 Awards for Excellence in Medical Journalism Program.

Cash awards of \$500 each will be offered in six categories: President's Plaque for Community Service; Daily and Weekly Newspapers with Circulation Under 50,000; Daily and Weekly Newspapers with Circulation Over 50,000; Magazines; Radio; and Television.

March 16 is the deadline for entries which must have been published or broadcast during 1981. Winners will be notified by April 16, and awards will be presented during the Annual Meeting of the FMA at Hollywood, May 5-9.

Contest rules and other information may be obtained from the Communications Department, Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203.

FMA-Produced Film Qualifies In Florida Emmy Contest

A half-hour film produced for television by the Florida Medical Association has qualified as a nominee for the Fifth Annual Florida Emmy Awards.

The announcement was made in November by Frank Gatto, President of the Miami Chapter of the National Academy of Television Arts and Sciences. Entitled "Edge of Life", the program was filmed in the emergency rooms of five Florida hospitals and depicts actual life threatening situations and their management by medical teams.

The film was shown on an 11-station statewide Florida network on January 12, 1981. The production already has won first place in the professional division of the Kinetic Image Film Festival at Clearwater, Fla.

Jim Stevens
is a camera man at NYU.
He shoots from a wheelchair.

**President's Committee on
Employment of the Handicapped
Washington, D.C. 20210**

1981. The International Year of Disabled Persons.



FMA AUXILIARY

Impaired Physician Update: From the Inside

A physician's spouse responded to a colleague friend of her husband who was voicing his concern over the increasing ill effects of alcohol on the husband's work performance: "Oh, please, don't mention it to him. You will only embarrass him," the wife begged.

It is of tremendous significance that Florida's Impaired Physician Program, now officially one year old, is alive and well. It is a program we found necessary to break through the bricks of ignorance, and fear, and isolation, and "embarrassment" that are the substance of the wall preventing our sick doctors from reaching out for the help they need.

We can already look back on a viable and active history, and can be proud of our achievements. Almost 50 recovering physicians and the families who love them have gone through the program; a successful series of workshops have been held to educate the "grass roots" physicians to the disease of addiction and the process of intervention; and many auxiliary educational presentations have been held at the county and state level. We have begun to chip away at the mortar holding those brick walls in place. We must also look back at administrative "kinks", communication blocks and educational hang ups, all "growing pains" that must be worked through in any new program.

Are the FMA and FMA Auxiliary *really* behind this program? I've heard this question many times. In our budget conscious society, let me hasten to answer — YES! All available dollars have come to the support of the Impaired Physician Committee and its activities. These funds have been used primarily in communication aids, hot line availability and office headquarters, and educational programs and seminars.

The very heart of the Impaired Physician's Program is something our interim Medical Director, Dolores Morgan, M.D., calls "tough love". The basis of "tough love" concerning alcoholism and abuse of other drugs among our physicians is education about the disease and intervention techniques to break up the circle of destruction it creates in the afflicted family.

In order to establish a network of caring, informed physicians around the state, intervention training workshops worth 14 CME, Category I credits, have been offered by the Florida Medical Foundation Committee on Impaired Physicians. More workshops are planned for the future. Information concerning these seminars is mailed to county medical society presidents prior to the sessions. On an Auxiliary level, it is vital that we encourage our physician spouses to attend one of these workshops and become involved.

The year has passed quickly, but it has already demonstrated to us that there is indeed a far better way to help the impaired physician and his family than to simply ignore them. The better way is to educate ourselves about the disease and continue in the challenge to treat it with all the science and love at our disposal. In this way, we won't "embarrass" him — we will save his life!

*Mrs. Frederick J. (Marybeth) Weigand
State Chairman
FMAA Impaired Physician Committee
Deltona*

First Class First Aid

In
your
office

In
their
homes

Recommend

NEOSPORIN® Ointment (POLYMYXIN B-BACITRACIN-NEOMYCIN)

- Broad-spectrum antibacterial
- Handy applicator tip

DESCRIPTION: Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neo-



mycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section). Complete literature available on request from Professional Services Dept. PML.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Motrin[®] vs aspirin w/codeine...

(ibuprofen)



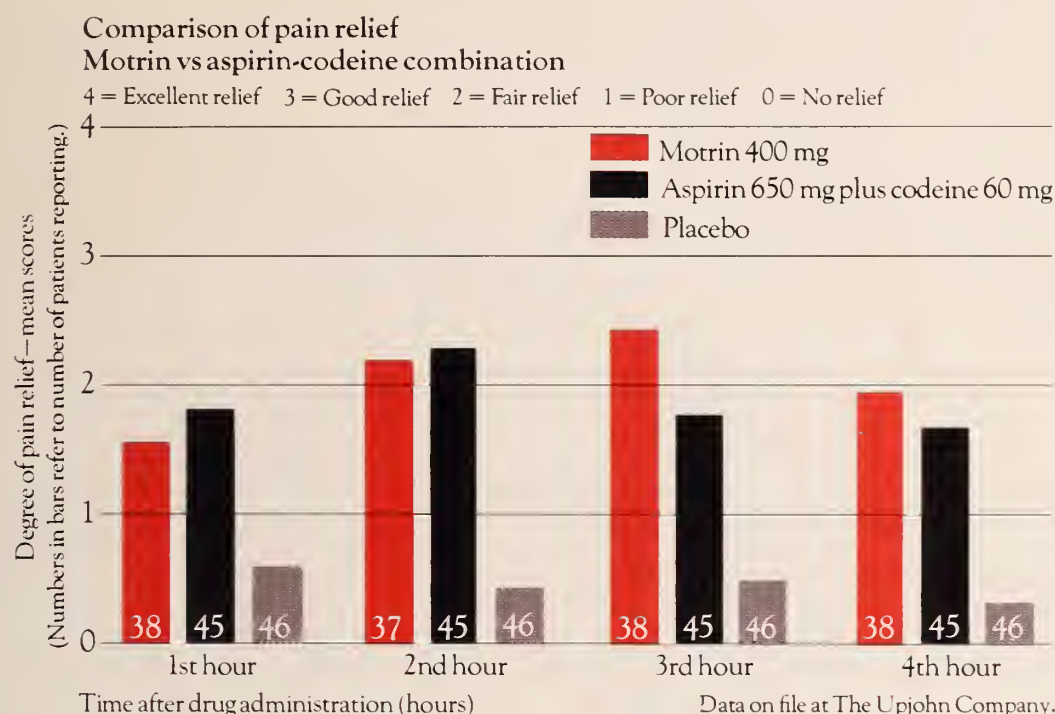
compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients.

In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups...

with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval.

Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.



One tablet q4-6h prn

For relief of mild to moderate pain:

Motrin[®] 400mg TABLETS
ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming • Nonscheduled
- Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin[®] (ibuprofen)

Now proved an effective analgesic for mild to moderate pain

Motrin[®] Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS)

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS)

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin.* Used concomitantly may decrease Motrin blood levels. *Coumarin.* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,^{*} epigastric pain,^{*} heartburn,^{*} diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,^{*} headache, nervousness. **Dermatologic:** Rash^{*} (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert

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MED B-4-S

It's time we took
arthritis seriously

It's a myth that arthritis is just the minor aches and pains of old age. It's a major crippler that attacks. Anybody. Anytime. 31 million Americans have it. There are almost a million new cases a year. And six out of ten are under 60. Symptoms can come and go for years. So if you don't know the warning signals, find out. If you'd like information that could help you—or you'd like to help us—write to the Arthritis Foundation, Box 19000, Atlanta, GA 30326.



ARTHRITIS
FOUNDATION



***You know
what you want
in Step-1
antihypertensive
therapy...***

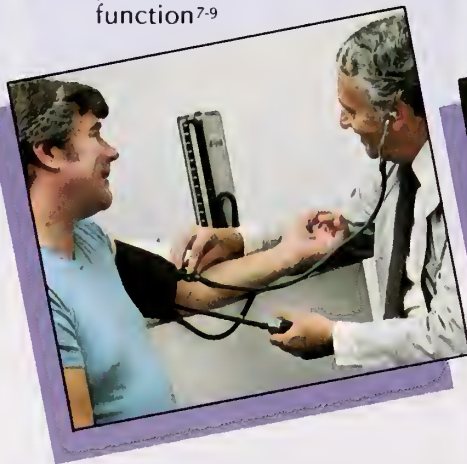
For your hypertensive patients,
Long-acting
Zaroxolyn[®] gives
(metolazone) Pennwalt

Efficacy

Start with Zaroxolyn because of its unsurpassed effectiveness in Step-1 therapy.^{1,4}

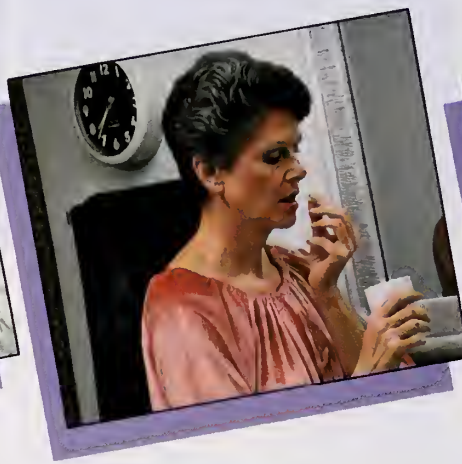
Stay with Zaroxolyn because it maintains effectiveness in long-term therapy^{1,5,6}... and minimizes the need for Step-2 agents.

- ☐ Zaroxolyn's effectiveness is maintained even in the presence of reduced kidney function⁷⁻⁹



Compliance

Stay with Zaroxolyn because it maintains 24-hour blood pressure control with simple once-daily dosage, and only 4% discontinue therapy due to side effects!



Safety

Stay with Zaroxolyn because clinically significant side effects are rare!

- ☐ Low incidence of changes in serum K⁺, glucose metabolism, or uric acid levels



you what you want

Compatibility

Add to Zaroxolyn easily if Step-2 agents become necessary.

- ☐ Permits lower doses of Step-2 agents to minimize side effects
- ☐ Allows flexible dosage titration, in contrast to fixed-dose combinations

Economy¹⁰

- ☐ Less expensive than most other diuretics
- ☐ More economical than hydrochlorothiazide in fixed-dose combination with triamterene or reserpine/hydralazine
- ☐ Costs less than beta-blockers
- ☐ Less expensive than methyldopa, clonidine, or prazosin



Start with...stay with...and add to...

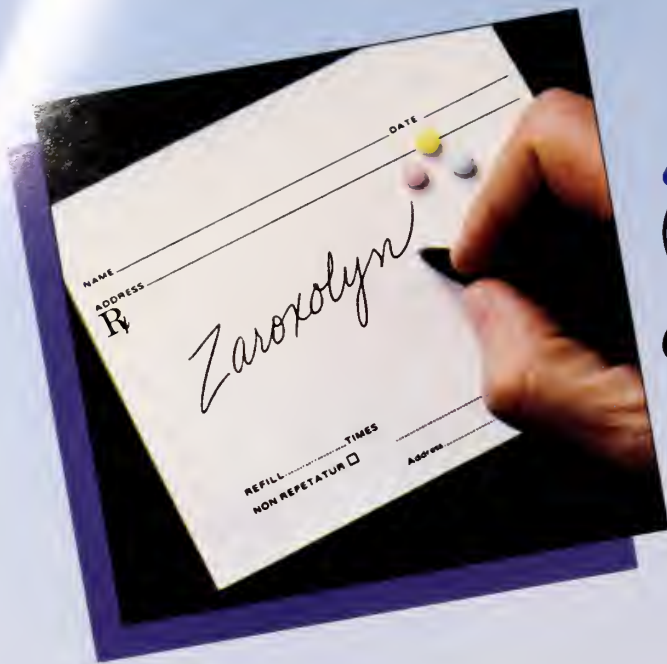
Long-acting

Zaroxolyn[®]

(metolazone)

Gives you what you want in
Step-1 antihypertensive therapy

Please see following page
for prescribing information.



Long-acting
Zaroxolyn[®]
 (metolazone) Pennwalt

2½ mg, 5 mg, 10 mg tablets

**Gives you what
 you want in
 Step-1 antihypertensive
 therapy**

- ☐ Unsurpassed Step-1 efficacy in mild to moderate hypertension
- ☐ True once-daily dosage for excellent patient compliance
- ☐ Positive side effect profile
- ☐ Strong foundation for stepped-care therapy
- ☐ Long-term economy

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents, and also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma, allergy or hypersensitivity to Zaroxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium

depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. Zaroxolyn 10 mg tablets contain FD&C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD&C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin sensitivity. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg, edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg

References: 1. Data on file, Medical Department, Pennwalt Pharmaceutical Division. 2. Sambhi MP, Eggena P, Barrett JD, et al: A crossover comparison of the effects of metolazone and hydrochlorothiazide therapy on blood pressure and renin angiotensin system in patients with essential hypertension, in Sambhi MP (ed): *Systemic Effects of Antihypertensive Agents*, New York, Stratton, 1976, pp 221-245. 3. Pilewski RM, Scheib ET, Misage JR, et al: Technique of controlled drug assay in hypertension: V. Comparison of hydrochlorothiazide with a new quinethazone diuretic, metolazone. *Clin Pharmacol Ther* 12:843-848, 1971. 4. Fotiu S, Mroczek WJ, Davidov M, et al: Antihypertensive efficacy of metolazone. *Clin Pharmacol Ther* 16:318-321, 1974. 5. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Current Therapeutic Research* 20:745-750, 1976. 6. Dornfeld L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Current Therapeutic Research* 18:527-533, 1975. 7. Puschett JB: Physiologic basis for the use of new and older diuretics in congestive heart failure. *Cardiovascular Medicine* 2:119-134, 1977. 8. Craswell PW, Ezzat E, Kopstein J, et al: Use of metolazone, a new diuretic, in patients with renal disease. *Nephron* 12:63-73, 1973. 9. Bennett WM, Porter GA: Efficacy and safety of metolazone in renal failure and the nephrotic syndrome. *J Clin Pharmacol* 13:357-364, 1973. 10. *Drug Topics Red Book* 1981, and manufacturers' suggested prices.

R_x DIVISION
PENNWALT
 ROCHESTER, NEW YORK 14623

WORTH REPEATING

Nursing Care or Nursing Practice

I can't remember just when it was that I first became aware that nurses were nowhere in view when I arrived on a ward to make rounds. It didn't happen all of a sudden and there still are nurses who seem to find the time to accompany the doctor; and for me, it was always a beneficial experience to be accompanied by the nurse. It seemed that I learned things about the patient that I never could have gleaned from the chart. Also, it seemed that those nurses had a better idea as to what my goals were for my patients and seldom had to call for clarification of an order. It appeared to be mainly the younger nurses who were such masters at disappearing. I attributed this to the probability that they were shy and insecure and for a long time took the blame, assuming that I must appear to be such a curmudgeon that I frightened them into the closets. Gradually, however, I realized that what I thought was an individual problem was actually universal. I now believe that, with exceptions, a nurse making rounds with the physician is a thing of the past. A revolution is taking place in patient care and this is but one manifestation. After all, the nurses have the game they are playing called nursing practice and the doctors have theirs, called medical practice, and while each is dedicated to the same goal, care of a sick patient, they are now functioning quite independently of each other.

It is strange that this has come about. Traditionally, the doctor has been the central figure in patient care. The patient contracts with a doctor to provide a certain service and that doctor is totally responsible from start to finish even though there might be need to use the services of ancillary personnel along the way. Theoretically this is true and lip service is paid to this concept. The doctor still must order whatever the patient receives in the way of tests, treatments, and services, but the doctor has little influence over the way the patients are handled or the manner in which the services are provided. There are now many members of a team providing services to a hospitalized patient and each proceeds in relative isolation. The nursing practice is but one game among the others being played by social workers, and various therapists, respiratory, physical, dietary, etc. It would seem that if this were a team, the physician, whom the patient selected to provide and supervise his care, would be the head of the team but that is not the way it is. Once his

orders are written, the doctor becomes just another member of the team, no more nor less important than any other member.

Examine a hospital medical record. Note the duplication of information. Even the history and physical examination are repeated, after a fashion. Observe how the descriptions and assessments (what a favorite word) duplicate each other and also observe how frequently they may contradict each other. See if you can view the nursing plan and tell me how it differs from a medical plan and also tell me when you were consulted as to your medical plan for a patient before the nursing plan is created. Please justify a nurse explaining the intricacies of an operation I am to perform when the nurse's experience with surgery has been obtained by reading about it. Finally, I have never been able to understand how the nursing service can make a discharge plan without consulting the physician who has contracted to provide the total care for the patient through a spell of illness. (There is a possibility that they have moved into a vacuum, to provide a needed service that was not being provided otherwise. If so, then I am analyzing the situation with too much bias and I apologize.)

I understand and sympathize with the nursing profession in its desire to upgrade its members' status. A nurse certainly is not a chambermaid and yet, nursing care denotes attending to the physical and emotional needs of the patient. This requires an in-depth education and training with basic knowledge of human behavior and disease processes as well as physiology, anatomy, and drug actions. It does not presuppose the depth of knowledge implied in the degree "Doctor of Medicine." It is time to quit tolerating this game playing. It is time to define nursing practice, distinguish it from medical practice, and identify the relationship of each type practice to the other. Unfortunately, the definitions of nursing practice which I have heard are indistinguishable from medical practice. I refer to this as unfortunate because I believe there are a great many nurses who are interested in bedside nursing and the hands-on caring for patients. This does not preclude a role, when desired, as administrators, teachers, and expert technicians in many clinical procedures. It does preclude independent clinical activity in the absence of supervision by a physician.

Their independent practice is being promoted by those who believe this to be a cheaper way to provide medical care. If this is satisfactory, then why require the more extensive education and training to obtain an M.D. de-

gree? The answer, of course, is that it is not satisfactory. In stating this, however, let us be absolutely certain that our motive is not that of "protecting our turf", and just as important, it must not even appear to be.

James K. Conn, M.D.
Tallahassee

Reprinted from: The Capital Medical Society Newsletter, September 1981.

Controlling the Cost of Medical Care

The most important single problem facing the medical profession today is the increasingly high cost of medical care. We have all been aware of this for many years but have, unfortunately, done little about it until recently. Our effort is late but maybe not too late.

The medical profession is besieged by criticisms and pressure from governmental agencies, consumer groups, news media and the general public. Most of these criticisms have been brought on, mainly or in part, by discontent with the increasing cost of medical care and a resulting frantic effort to do something — just anything — to control those costs.

The list of proposed solutions is almost endless: The Federal Trade Commission's moves against relative value schedules, HEW guidelines, Health Service Agencies, PSRO, federally subsidized HMO's, physician directories, second opinion programs, unnecessary operation disclosures, medical audits, utilization review, certificates of need and decertification, physician advertising to improve competition, patient self-diagnosis and self-treatment programs and accusations by the FTC concerning price fixing, conflict of interest and restraint of trade. All of these and more are aimed primarily at cost control and none have had much impact.

A strange new terminology is being applied to our profession. Most of these words or phrases are being widely used to describe us and our activities but nobody seems to know precisely what they mean or even attempts to give a definition. A few examples: providers, consumers of Health Care (whatever that is), cost-effectiveness, medical public utility, reimbursement restrictions (? rationing), market incentives, capital expenditure limits, physician extenders and multiphasic health evaluations. If all of this sounds like an effort to bring our profession down to the level of the market place, you have heard correctly. That's just what it is.

The concern and criticism are not entirely unjustified. The costs of medical care continue to soar. The nation spent \$212.2 billion dollars for medical care last year and it is estimated that the expenditure for 1981 will be \$275 billion. Somebody has to do something.

Physicians have been slow to recognize and admit their part of the responsibility for these rising costs. It has been all too easy to point an accusing finger at inflation, government spending, the necessity for defensive medicine, the huge cost of newer and more sophisticated equipment and techniques and numerous other factors over which doctors have little or no control. All of this is true but doctors, and others, are now beginning to realize that physicians have almost complete control over the utilization of those high priced services. Eighty percent of the total expenditure is on the direct order of some doctor. We are the ones who make the decisions about hospital admissions and discharges, scheduling of operations, ordering tests and examinations and prescribing therapeutic modalities. We are the ones who control the spending of the money. We must recognize our responsibility and take the necessary steps to accept this responsibility.

Many of our major medical societies have become increasingly aware of the necessity to control costs. They are now making concerted efforts to determine causes and to make recommendations to help solve the problem. The National Commission on the Cost of Medical Care and the voluntary Cost Containment Program are examples of their activities. Many state medical societies and specialty societies have established cost containment committees. The chances are that your hospital has an active formal cost containment program. An increasing number of medical schools are teaching the importance of costs to medical students. How effective have these endeavors been? Nobody really knows.

The results are difficult to measure. Most of these efforts have been directed at the overall problems and the individual physician has not yet become directly involved.

It is my belief that the desired end can be reached only if the physician is, in some way, motivated to participate within his own practice. He will do so only on a voluntary basis because he can not be coerced. We are tired of being told that if we don't change our ways somebody else will do it for us, thus raising the spectre of a tyrannical government. Make a rule and ten doctors will find ten different ways of getting around it if they don't like it. On the other hand, physicians, like the rest of the human race, will usually do something if it is in their best interest to do so. There is no question that it is now in our best interest to control the cost of medical care.

Generally speaking, doctors have not been fully conscious of the fact that they do exert such direct control over the utilization of medical care and thereby the overall costs. Physicians are constantly and properly concerned about maintaining and improving the availability and quality of the care which we provide. For a brief period, you may be the most important person in the patient's life. He trusts you to protect his health and his pocketbook. To a great extent, we have succeeded in the former and failed in the latter.

What specific methods can a physician use to control the costs of care and still maintain the quality of care? There are many of them and none are new. They just need to be put into effect. The relationship between ideas and action is sometimes a distant one.

First of all, let's discuss the rather delicate subject of physician's fees and get it over with. The problem of fees has been over-emphasized by the government and the news media in terms of their true effect on over-all costs. Actually, fees make up only about 18% of the total cost but are a highly visible factor and easy to criticize. The recent nationwide coverage of the 60 Minutes television program and a recent editorial in our local newspaper are examples of the flak we may expect to continue. Increases in fees will persist and are made necessary for the physician to maintain his net income in the face of rapidly increasing overhead. Actually, physicians, like most other Americans, have experienced a decrease in their net purchasing power in recent years. It is suggested that, when you do raise your fees, do so on a logical, rational and well-considered basis and limit the increase to those made necessary by the increased costs of practice and the increased costs of living. Fee abuses and outright fraud do exist and need to be curbed but add only a tiny fraction to the total costs and will not be discussed here.

We should use all methods available to make our delivery of medical care more efficient. Increased efficiency in our practice is more frequently discussed in

terms of saving the physician's time or increasing his income. These commendable goals can then be translated into a decrease in costs to the patient. For example, a doctor's net income can frequently be increased by 25% to 40% just by moving into a well-designed office that is provided with good patient-care space and equipment. The AMA has provided courses on efficiency and you may obtain information on these by writing to the Department of Practice Management, AMA Headquarters.

Doctors have increasingly structured their patient care around the hospital. There have been many reasons for this trend such as third party payments, available facilities, malpractice threats and convenience to both doctor and patient. When a daily bed rate was \$12.00 and a CBC was \$2.00, hospital admission for convenience was not too bad. Now, however, with daily hospital costs of \$300.00 or more, the trend must be reversed. Ambulatory care, home care, nursing homes, out patient diagnostic facilities and out patient surgical facilities should be used as much as possible. Admit patients to the hospital only when proper diagnosis and treatment cannot be done elsewhere. We can save billions of dollars.

If hospital admission is necessary, utilize preadmission diagnostic studies and therapy as much as possible in order to decrease the time between hospital admission and definitive treatment. Most routine x-rays, laboratory work, scans and even consultations can be obtained prior to admission. Of course, there is some difficulty here in regard to insurance payments and some inconvenience. Nobody said it was going to be easy. Cost control is the goal.

Everybody agrees that good medical care dictates that we must examine our indications for therapy critically and seek consultation with another physician without hesitation in any questionable situation. When these basic principles are not followed, for whatever reason, the result may be not only poor medical care but increased costs to the patient. For example, our prescribing habits can be significantly improved. Generic drugs should be used when they are therapeutically equivalent. Some antibiotics cost 20 times as much as others of essentially the same effectiveness. Learn the difference. Prescribe only the amount of medication which is going to be used. The home medicine cabinets of America contain untold wealth in unused medications. Consultations (the new term is second opinions) have always been used by the medical profession and should continue to be used when indicated. Too many consultations can be as bad as, or worse than, too few. Only the doctor and his patient can make this judgement based on a careful analysis of the facts in each situation.

We must employ only those diagnostic and therapeutic modalities which are necessary to proper care of the patient. We have available a huge number of proce-

dures, some quite expensive or hazardous, about which we have insufficient information to be truly certain of their value. We must realize that large amounts of information do not necessarily equate with better patient care and may, in fact, be misleading. The physician who orders lots of tests may be showing his intellectual laziness rather than clinical astuteness. He may just be praying that something will show up. Be suspicious of tests that are obtained "for the sake of completeness," "to establish a baseline," "for teaching purposes" or "to monitor the progress." Some of these may be indicated at times but be suspicious. Who is ordering too many studies and too many therapeutic modalities? The old guys say the young guys are doing it. The young guys point at the Residents. The Residents say they are just following the example set by their teachers who are both old guys and young guys. Who is doing it? Everybody.

No one really knows how much the practice of "defensive medicine" adds to the cost of medical care but few doubt that it is a very large sum. Opinion polls of physicians reveal that a large percentage of doctors state that fear of malpractice has made them order diagnostic examinations, obtain consultations and employ therapy only to protect themselves in case of a lawsuit. Some lawyers state that the situation has made doctors more alert and that the public benefits from their new attitude. Most physicians know that only a questionable small benefit is derived from purely defensive medicine and wish it could be deleted from their practice. It can be. A recent detailed study by Drs. Harold L. Hirsh and Edward R. White, who are also lawyers, has revealed that ordering many diagnostic tests is no protection against litigation. The appropriateness and proper timing of the tests, not the number, is the deciding factor. In other words, base your decisions on the quality of care and you are as safe as you can be.

The list of things the individual physician can do goes on an on: (1) Make every patient's hospital stay as brief as possible. Don't delay discharge until Cousin Mathilda comes down from Detroit. (2) Become informed about the costs of individual items. How much does an

SMA cost? A scan? A bottle of I. V. fluids? Cost awareness is the key to cost control. (3) Lists of routine orders frequently are not appropriate for every patient. Individualize. (4) Do not recommend programs of chemotherapy, radiation therapy or surgical operations solely for purposes of emotional support. A caring and attentive physician is much more supportive than a shot, a rod or a scalpel. (5) Get patients out of ICU and CCU at the earliest safe moment. The cost is horrendous. (6) Keep patients out of the Emergency Room for non-emergency care. The average Emergency Room charge is much more than the usual office visit fee. (7) Speak out in conferences, teaching clinics and committee meetings when you suspect that insufficient attention is being paid to costs. One cost containment convert is able to have a salutary effect on his peers even at the risk of becoming tiresome. (8) Home Health care can be very beneficial as a substitute for prolonged hospitalization. Do not use it to supply maid service to lonesome little old ladies. (9) Do not be a party to improper patient sharing. This is simply fee splitting in another guise. (10) Put stop orders on diagnostic studies and therapeutic modalities whenever you can properly do so. Respiratory therapy, daily blood gases, blood cultures, compresses and antibiotics have been known to go on far beyond the time originally intended or the time of usefulness just because the doctor forgot. (11) Think about the real value for diagnosis or treatment before you order another x-ray or scan. It has been reliably estimated that seven billion dollars of unnecessary x-ray examinations are made in this country every year. Scans and other imaging procedures are notoriously abused.

It is most disconcerting that our national health has not improved in proportion to the tremendous increase in expenditures. Our profession is the greatest on earth and medical care in the United States is the best in the world. It is our duty to preserve this heritage for future generations rather than to stand by and watch it slip away, not because of lack of quality of care, but only because we did not control the costs. Doctors **can** control the costs of medical care — if they will.

Reprinted from: The Stethoscope, Bulletin of the Volusia County Medical Society, December 1980.

*George H. McSwain, M.D.
Member, Cost Containment Committee
American College of Surgeons
Daytona Beach*

Goodbye? Mr. Chips

Recent hospitals "by-laws" have made issue with the doctor of 65 or more. That magic number is regarded as when physical and mental process have reached a suspected stage of deterioration. Therefore, for the good of all, as well as the "old boy himself," he should be removed from a respected and established position to one of question and changing stability. Exceptions have been made and even a grace period offered — that is, if certain conditions are met, a certificate of physical and mental ability offered to the reviewer or reviewers to decide whether this aging physician is capable of continuing his specific field of work. However, at some specific later age, he is considered totally incapable — no matter the evidence of ability.

At the conclusion of World War II, the period of 1945-1955, the Jacksonville medical population rose strongly. Those physicians are now suspected as to their abilities to meet the expected standards of medical practice. Let us pause and consider.

There is a group of physicians who feel, once financial security is achieved, that the greatest thing for them would be to retire from all the obligations and ingrati-tudes that go with the practice of medicine. "It ain't what it used to be!" So, when the opportunity arrives whether it be 40, 50, or 65 years of age, they leave with a whoop and a smile — and they are still smiling when you encounter them years later.

There is another group too. Financial success or not, they continue to see patients and want to continue to practice their brand of medicine. This, has been, and continues to be their way of life. They continue to read recent journals, attend seminars frequently and participate in teaching. They do their work that is equivalent, and in some instances superior, to their colleagues. They differ in age — and that is what seemingly makes the difference.

There are many factors to consider as a person reaches 65 years or more. Fatigue and decreased endurance may occur. Though that may be a deficiency, it ranks less than laziness and indifference. Disease has no respect for age and many types appear earlier than 65: multiple myeloma and other malignant diseases, Alzheimer's disease of premature senility, Parkinson's with its tremors, cataracts, etc., etc. It seems, therefore, that each practitioner is susceptible to disease and should be examined and show proof of good health each year, especially after reaching the age of 40. As I seek a typical 65 plus year old disease, I can only think of "prostatic hypertrophy." Though it has its problems, it does not interfere with good medical skills.

Perhaps the situation is the year of medical errors producing increased medical malpractice errors. I have no statistics, but from personal knowledge, those cases involve the doctor younger than 65.

Thus, I present my case. A capable and intelligent man at 65 and older is an asset to his community. Big business does not discard their executives at or after 65. Political leaders, as our President and legislative representatives are elected and serve their tenures. Why, in medicine that is dependent on knowledge and experience, do we feel that when a specific numerical year is attained, that person, no matter how well endowed, is considered useless or even a menace? Every doctor should be evaluated on an annual basis. It should begin when he applied for privileges and continue thereafter. To base annual evaluations with written requirements of proof of physical and mental status as well as proficiency beginning at age 65 seems without logic or reason. Perhaps the answer may be compared to the familiar call of the harried subway attendant at rush hour, "Move over people and make room for more!"

Reprinted from: Jacksonville Medicine, The Bulletin of Duval County Medical Society, November 1981.

*Seymour Morse, M.D.
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MEETINGS

Accepted by the FMA Committee on Medical Education for Mandatory Credit

FEBRUARY

Florida Midwinter Seminar, Ophthalmology and Otolaryngology, Feb. 1-6, Fort Lauderdale. For information: Gaby Kressly, 405 N.E. 144 St., Miami 33161.

Sixteenth Annual Symposium on Cosmetic Surgery, Feb. 4-6, Cedars of Lebanon Health Care Center, Miami. For information: Debbie Zayas, 1400 N.W. 12th Ave., Miami 33136.

Third Annual Conference in Gastroenterology, Feb. 4-7, Lake Buena Vista, Florida. For information: S.N. Tewari, M.D., 1111 Kentucky Ave., Winter Park, Florida 32789.

Second Symposium on Burn Care, Feb. 5-6, Gainesville. For information: JHM Health Center, Box J-233, Gainesville 32610.

Breast Cancer Conference, Feb. 5-6, St. Joseph's Hospital, Tampa. For information: Ralph Jensen, M.D., P.O. Box 4227, Tampa 33677.

The Postgraduate Seminar in the Fundamentals of Otolaryngologic Allergy and Clinical Applications, Feb. 6-11, 1982, St. Petersburg Beach. For information: Hueston C. King, M.D., 4675 Ponce De Leon Blvd., Coral Gables 33146.

Conference in General Medicine and Family Practice, Feb. 8, International Hospital, Miami. For information: Lynn P. Carmichael, M.D., Department of Family Medicine, University of Miami School of Medicine, Miami 33101.

Family Practice Grand Rounds, Feb. 10, 24, Jacksonville. For information: Mary P. Kellogg, M.D., 655 W. 8th St., Jacksonville 32209.

Basic Mechanisms and Clinical Applications of Calcium Antagonists, Feb. 11, Miami. For information: Paul S. Swaye, M.D., 4701 N. Meridian Ave., Miami Beach 33140.

Calcium Antagonists, Feb. 16, Fort Lauderdale. For information: Jon R. Fichtelman, M.D., Holy Cross Hospital, Fort Lauderdale 33307.

Medical Update — 1982, Feb. 17-19, South Miami. For information: Leonard Zwerling, M.D., 7400 S.W. 62nd Ave., South Miami 33143.

Fourth Annual Oncology Update, Feb. 19-20, Cedars of Lebanon Health Care Center, Miami. For information: Debbie Zayas, 1400 N.W. 12th Ave., Miami 33136.

Third Annual Family Practice Update, Feb. 15-20, Daytona Beach. For information: Richard W. Dodd, M.D., Halifax Hospital, Daytona Beach 32015.

The Professional and Chemical Dependency — Challenge for the 80's, Feb. 18-21, West Palm Beach. For information: Ronald J. Catanzaro, M.D., Palm Beach Institute Foundation, West Palm Beach 33405.

The Pulmonary Cripple, Feb. 20-21, Melbourne, Fla. For information: George H. Mix, M.D. and J. L. Weare, M.D., 1304 S. Oak St., Melbourne 32901.

Clinical Management of Coronary Disease and Exercise Testing, Feb. 19-21, Fort Lauderdale. For information: Charles E. Aucremann, M.D., 7300 Demens Dr., South, St. Petersburg 33712.

Intensive Care for Neurological Disease and Trauma, Feb. 24-28, Miami Beach. For information: Div. of Continuing Education D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami 33101.

Ninth Annual Selected Topics in Urology, Feb. 25-27, Gainesville. For information: JHM Health Center, Box J-233, Gainesville 32610.

Midwinter Seminar in Obstetrics and Gynecology, Feb. 25-27, St. Petersburg. For information: James M. Ingram, M.D., University of South Florida College of Medicine, Tampa 33612.

Ninth Annual Pediatric Dermatology Seminar, Feb. 25-28, Miami. For information: Guinter Kahn, M.D., 16800 N.W. 2nd Ave., Miami 33169.

Tampa Bay Winter Cardiovascular Seminar, Feb. 26-27, Tampa. For information: American Heart Association, P.O. Box 4835, Tampa 33677.

Traditional and Modern Chinese Acupuncture, Feb. 27-28, Lake Buena Vista, Fla. For information: Joseph Bubenias, 50 Maple Place, Manhasset, N.Y. 11030.

Oculoplastic Symposium, Feb. 27-Mar. 7, U.S. Virgin Islands. For information: Lawrence B. Katzen, M.D., 2889 10th Avenue North, Lake Worth 33460.

Spinal Cord Injury, Feb. 28-Mar. 4, Walt Disney World, Orlando. For information: William Brown, M.D., P.O. Box 016960, Miami 33101.

MARCH

Basic Neurology for Psychiatrists and Generalists: A Comprehensive Review Course, Mar. 1-5, Miami. For information: University of Miami School of Medicine, Dept. of CME, P.O. Box 016960, Miami 33101.

Postgraduate Medical Refresher Course, Mar. 1-12, Fort Lauderdale. For information: Charles E. Aucremann, M.D., 7300 Demens Dr. South, St. Petersburg 33712.

Current Clinical Concepts in Otolaryngology 1982, Mar. 3-4, Miami. For information: University of Miami School of Medicine, Dept. of CME, P.O. Box 016960, Miami 33101.

Comprehensive Review in Toxicology, Mar. 4-6, Orlando. For information: Charles E. Aucremann, M.D., 7300 Demens Dr. South, St. Petersburg 33712.

Pan American Symposium on Cancer of the Head and Neck, Mar. 5-6, Miami. For information: University of Miami School of Medicine, Dept. of CME, P.O. Box 016960, Miami 33101.

Internal Medicine 1982, Mar. 7-12, Miami Beach. For information: J. S. Bocles, M.D., P.O. Box 016960, Miami 33101.

17th Annual Postgraduate Course in Internal Medicine, Mar. 7-12, Bal Harbour, Fla. For information: J. S. Bocles, M.D., P.O. Box 016960, Miami 33101.

14th Annual Teaching Conference in Clinical Cardiology, Mar. 10-13, Bal Harbour, Fla. For information: Michael Gordon, M.D., P.O. Box 016960, Miami 33101.

Family Practice Grand Rounds, Mar. 10, 24, Jacksonville. For information: Mary P. Kellogg, M.D., 655 W. 8th St., Jacksonville 32209.

Problems in Rheumatology, Mar. 11-14, St. Petersburg. For information: Bernard F. Germain, M.D., Box 19, University of South Florida College of Medicine, Tampa 33612.

Symposium on Glaucoma: Patient Evaluation, Surgical and Laser Therapy, Mar. 12, Gainesville. For information: JHM Health Center, Box J-233, Gainesville 32610.

Intensive Care for Neurological Disease and Trauma, Mar. 14-18, Kissimmee, Fla. For information: Gloria Allington, P.O. Box 016960, Miami 33101.

13th Annual Topics in Internal Medicine, Mar. 18-20, Gainesville. For information: JHM Health Center, Box J-233, Gainesville 32610.

St. Moritz 1982 — Advances in Diagnostic Imaging, Mar. 21-28, Moritz, Switzerland. For information: Edward A. Eikman, M.D., 3100 East Fletcher Ave., Tampa 33612.

Orthopaedics for Family and Emergency Physicians, Mar. 24-27, Lake Buena Vista, Fla. For information: Allan W. March, M.D., JHMHC, Box J-222, Gainesville 32610.

Nutrition in Chronic Disease, Mar. 25, Tampa. For information: J. J. Mamel, M.D., Div. of Digestive Diseases and Nutrition, USF College of Medicine, Box 19, Tampa 33612.

Postgraduate Course on Interesting Topics in Orthopedics — 1982, Mar. 25-27, Palm Beach Gardens. For information: Michael S. Zeide, M.D., 2501 N. Flagler Drive, West Palm Beach 33407.

Interesting Topics in Orthopedics, Mar. 25-27, Sheraton Resort, Palm Beach Gardens. For information: Michael S. Zeide, M.D., 2501 N. Flagler Drive, West Palm Beach 33407.

Practice Update in Obstetrics and Gynecology, Mar. 31-Apr. 2, Kissimmee, Fla. For information: Amelia C. Cruz, M.D., Dept. of Ob/Gyn, University of Florida College of Medicine, Gainesville 32610.

APRIL

Fifteenth Family Practice Review, Apr. 5-9, Kissimmee, Fla. For information: University of Florida College of Medicine, Box J-233, Gainesville 32610.

Comprehensive Review Course for ECFMG, FLEX and VQE (in Spanish), April 5-July 16, Miami. For information: Rafael Penalver, M.D., University of Miami, P.O. Box 016960, Miami 33101.

Spinal Surgery: A Combined Neurosurgery and Orthopedic Advanced Course, Apr. 5-9, Miami Beach. For information: Dept. of Orthopedics and Rehabilitation, University of Miami School of Medicine, P.O. Box 016960, Miami 33101.

Clinical Management of Coronary Disease and Exercise Testing, Apr. 16-18, Orlando. For information: Charles E. Aucremann, M.D., 7300 Demens Dr. South, St. Petersburg 33712.

New Developments in Inhalation Anesthesia and Clinical Application in Special Situations, Apr. 24-25, Howard Johnsons Hotel, Pensacola Beach. For information: Warren W. Sears, M.D., 1717 N. "E" Street, Suite 205, Pensacola 32501.

MAY

Third Annual Advanced Cardiac Life Support for Physicians, May 7-8, Cedars of Lebanon Health Care Center, Miami. For information: Debbie Zayas, 1400 N.W. 12th Ave., Miami 33136.

Master Approach for Cardiovascular Problems, May 29-June 1, Walt Disney World, Fla. For information: Louis Lemberg, M.D., Dept. of Cardiology, University of Miami School of Medicine, Box 016960, Miami 33101.

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INTERNIST seeking to share well equipped 2,000 sq. ft. office with another specialist. Well located in a professional building in Coral Gables, Florida. Contact Dr. Veliz, 475 Biltmore Way, Suite 206, Coral Gables, Florida 33134. (305) 445-1115.

IMMEDIATE OPENINGS FOR ONE FAMILY PRACTITIONER AND ONE INTERNIST: Board certified or eligible for multispecialty association. West coast of Florida, 30 miles north of Clearwater and Tampa. Minimum guarantee with incentive first year, partnership opportunity after first year. Send CV to Michael T. Gossman, Community Health Center, 1150 Plaza Drive, New Port Richey, Florida 33553.

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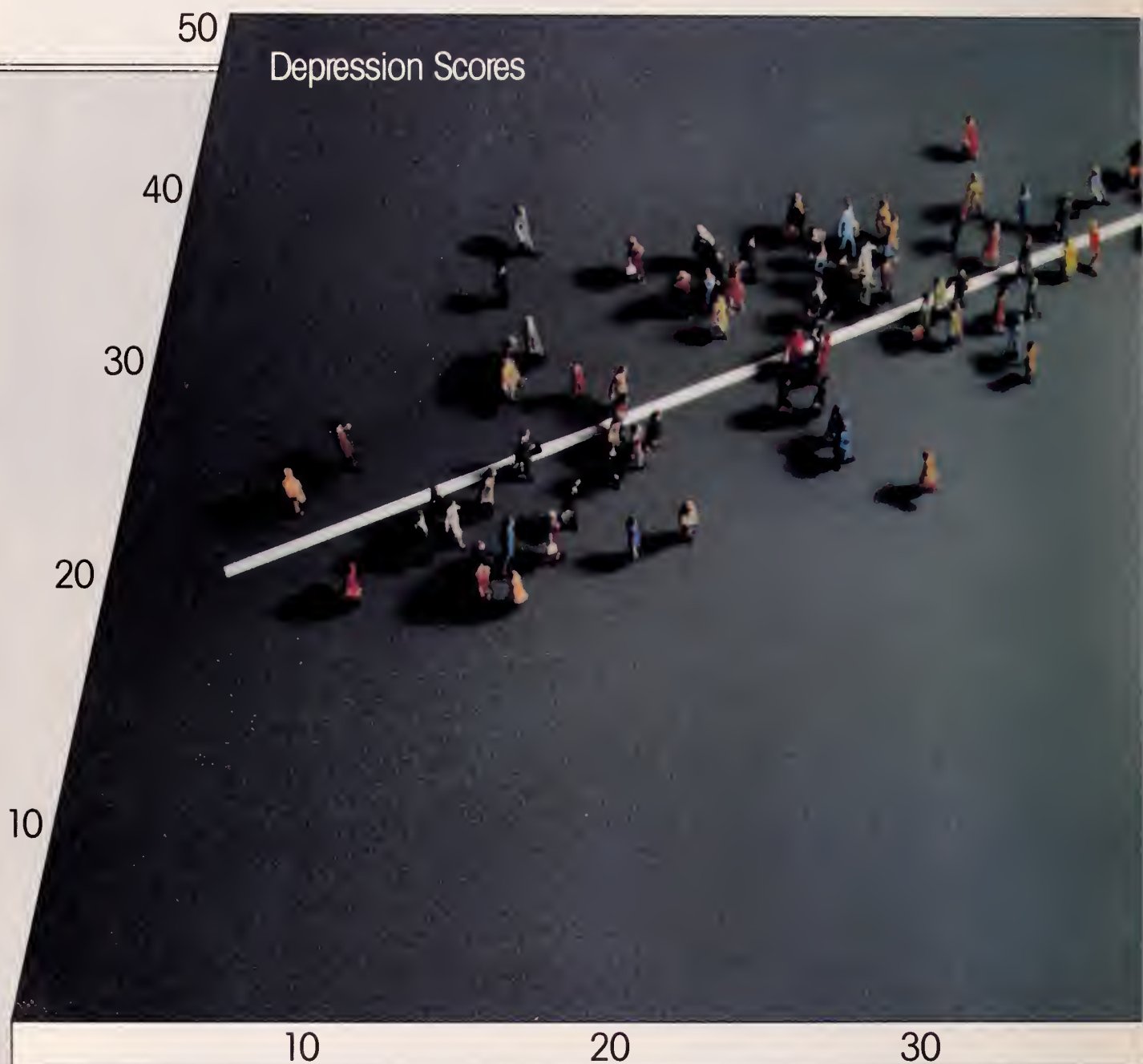
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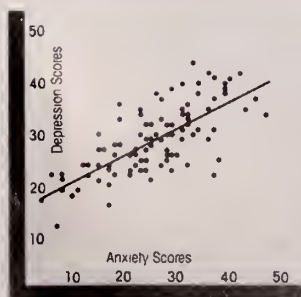
FOR THE 7 OF 10 NONPSYCHOTIC



Clear correlation between anxiety and depression³

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone; more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

³Adapted from Claghorn, J. The anxiety-depression syndrome. *Psychosomatics* 11:438-441, Sept-Oct 1970.



DEPRESSED PATIENTS WHO ARE ALSO ANXIOUS^{1,2}

Most depressed patients are also anxious...

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.^{1,2} One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.³ As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.⁴ Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

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References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, ed. Jorvik ME. New York, Appletan-Century-Crafts, 1977, p. 316. 2. Scholtzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry* 35:1359-1365, 1978. 3. Claghorn J: The anxiety-depression syndrome. *Psychosomatics* 11:438-441, 1970. 4. The Task Force on Late Neurological Effects of Antipsychotic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry* 137:1163-1172, 1980. 5. Feighner JP *et al*: A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacology* 61:217-225, 1979.

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Please see summary of product information on next page.

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Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide)

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated. Sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.

In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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Special Auxiliary Issue

The February issue of the Journal of the Florida Medical Association has been compiled by members of the FMA Auxiliary with Mrs. LaVere G. (Mae) White serving as Guest Editor. The articles focus on the special projects and accomplishments of the Auxiliary. The JFMA editorial staff is grateful for their involvement, both in this special issue and in community service.

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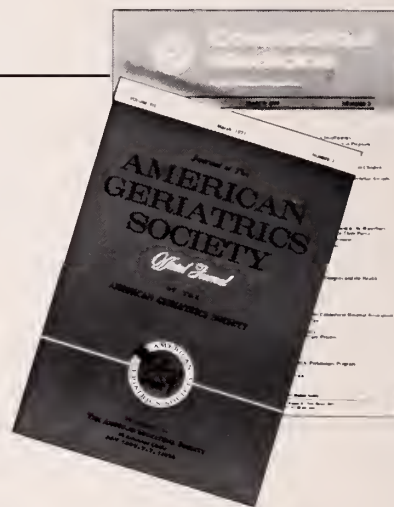
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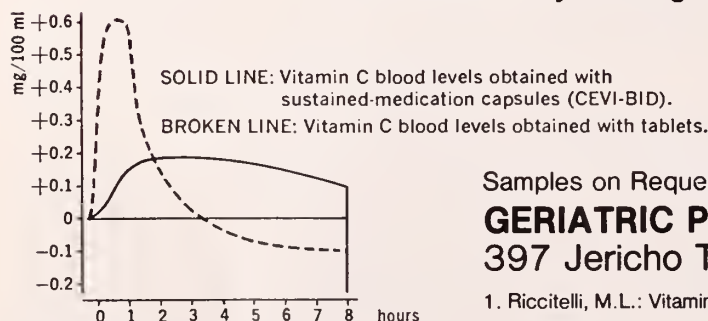
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1. Riccitelli, M.L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20:34, 1972.
2. Riccitelli, M.L.: Vitamin C—A Review. Conn. Med. 39:609, 1975

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President's Page

In Praise of the Florida Medical Association Auxiliary

It is my privilege and pleasure on behalf of the officers, Board of Governors, and all of the nearly 14,000 members of the Florida Medical Association to offer congratulations to the Florida Medical Association Auxiliary as it begins its 57th year of service to the people of the State of Florida. From the time of its founding on May 5, 1926, in Gainesville, to the present day, the work of the Auxiliary has been an outstanding example of service by a group of hard working and able individuals.

The organization was founded as the Women's Auxiliary to the Florida Medical Association, but in 1976 its name was changed to the Florida Medical Association Auxiliary to conform with the policies established by the American Medical Association Auxiliary and to reflect the fact that the Auxiliary is made up of both women and men who are bound together by the fact that they are married to physicians. Although women are still substantially in the majority in the Auxiliary, men are becoming members in ever-increasing numbers both in Florida and in other states around the country.

The current level of activities of the Auxiliary and the great support that the Auxiliary provides the FMA are particularly important to consider in view of the comments made by Dr. William H. Rowlett of Tampa when he addressed the Auxiliary in 1934 during his term as FMA President. Dr. Rowlett said, "How well I remember when they first began to talk about the Woman's Auxiliary in our State Association. No one seemed to know very much about it, and they all seemed rather timid about its possibilities. We finally decided to give it a trial, and as one of our members expressed it, he was willing to try anything once. I think most of us were afraid that you women would take our meetings away from us. Some of the more gallant members agreed to keep a watchful eye on you and to guide you."

It is too bad that Dr. Rowlett is not with us today to see how well the Auxiliary has performed in the past 56 years. I know that he and the other members of the FMA leadership 50 to 60 years ago would be very proud of the organization they helped to get started.

The Auxiliary has been particularly interested in, and supportive of, education in the medical field. During the past six years, through 1981, they have contributed to the American Medical Association Education and Research Foundation (AMA-ERF) a total of \$389,349.15. Much of this has been given to the medical schools of Florida. They have also given continuing financial support to medical students, interns, residents, nurses and others who have needed financial assistance during their periods of formal education and training.

The Auxiliary has participated in many projects at the local level in helping to improve the standards of health in school children at all ages. The variety of worthwhile projects on which the Auxiliary has embarked as a means of fund-raising for AMA-ERF and other worthy organizations is far too numerous and varied to be mentioned in any detail here. Suffice it to say that the projects are characterized by imagination, ingenuity and success.

There are now approximately 5,700 members in the FMA Auxiliary. I would urge every married member of the FMA to encourage his or her spouse to become affiliated and actively involved with the Auxiliary.

In recent years it has become obvious that Auxiliary involvement in political and legislative activities has been extraordinarily important. Auxilians are learning the importance of political activity with involvement in candidate campaign organizations. Such involvement has a very positive effect when the candidates are elected to office. By the time they have been elected, candidates recognize the abilities and effectiveness of the Auxilians

and are much more responsive to their comments and suggestions.

It is likely that individual involvement in political campaigns will become even more important if, as is anticipated, the Florida Legislature develops an apportionment plan providing for single member districts for the Florida Senate and House of Representatives. If the single member district plan prevails, political campaigns for the Legislature will cover small geographical areas and will be related much more to individual contacts with voters than to the use of television and radio campaigning. Money will become relatively less important to these campaigns as the need increases to contact voters on a person-to-person basis. The importance of Auxiliary involvement in such campaigns is obvious.

For many years now the Auxiliary has had a Day in the Legislature as an important part of its legislative program. On these occasions, Auxilians from all over the State have visited in Tallahassee while the Legislature is in session. Members of the Auxiliary have participated

enthusiastically and have taken the opportunity to talk with their local legislators about many important issues of the day. All reports indicate that the members of the Legislature thoroughly enjoy these visits. It should also be pointed out that the Auxiliary has been very effective in leading local efforts supporting or opposing various legislative proposals.

These words outline only a small part of the Auxiliary and its importance to the FMA. This issue of *The Journal of the FMA* is devoted to the Auxiliary. A study of the various articles will give additional information concerning the scope and effectiveness of the Auxiliary. All of us who have had an opportunity to be involved closely with the Auxiliary recognize that the leaders of the FMA made a wise decision over 50 years ago when they gave their support to the formation of the Auxiliary. It is our pleasure to commend the members of the Auxiliary for their achievements and to re-emphasize our pledge to give them continuing support in every possible way.

Sanford A. Pullen, M.D.



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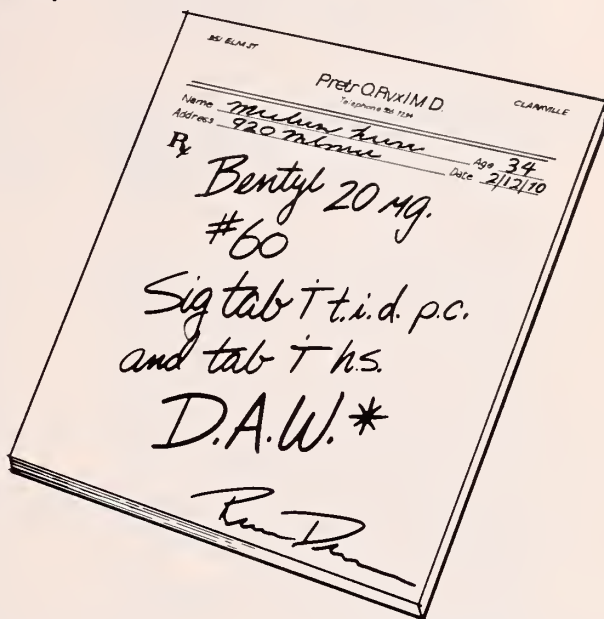


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- ⊕ Significant pharmacologic effect in the distal colon compared to placebo,¹ shows how Bentyl controls abnormal motor activity in the irritable colon patient.*

*This drug has been classified "probably" effective for this indication.

Merrell Dow

Reference:

1. Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

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Brief Summary

INDICATIONS

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THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy), obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia, urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg capsule and syrup. **Adults:** 1 or 2 capsules or teaspoonfuls syrup three or four times daily. **Children:** 1 capsule or teaspoonful syrup three or four times daily. **Infants:** ½ teaspoonful syrup three or four times daily (Dilute with equal volume of water).

Bentyl 20 mg. **Adults:** 1 tablet three or four times daily

Bentyl Injection. **Adults:** 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

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Summary of the FMA Board of Governors Meeting January 16, 1982

The following is a summary of the major actions taken by the Board of Governors at its meeting January 16, 1982.

PROFESSIONAL LIABILITY

Mandatory Coverage for Hospital Staff Privileges

THE BOARD:

Reaffirmed FMA policy of opposition to mandatory malpractice insurance for hospital staff privileges and reiterated policy adopted by the House of Delegates that:

"The Florida Medical Association questions the advisability of a defensive requirement of some Florida hospitals that each physician carry a specific amount of personal professional liability insurance as a prerequisite to hospital staff privileges and believes this to be an unnecessary requirement imposed on physicians.

"The FMA further reaffirms its belief that such a requirement for hospital privileges may actually encourage, rather than discourage the proliferation of unwarranted legal actions against both physicians and hospitals.

"The FMA is confident that such a requirement in no way insures quality care to the public but rather, may actually work to the disadvantage of the patient by imposing such financial constraints on some types of physicians so as to exclude them from hospital practice."

It is the opinion of the FMA that the primary consideration for hospital medical staff appointments should be based on professional qualifications of the individual physician.

Expressed support in principle for the concept of professional malpractice screening boards and authorized the FMA PLI Committee to pursue further development of the proposal.

Malpractice Screening Boards

Patient's Compensation Fund

Reaffirmed policy adopted by the Board of Governors at the meeting in October, 1981, in approving the report and recommendations of the Committee on PLI

(see November issue of *FMA Journal*) that the Patient's Compensation Fund be made actuarially sound by the Florida Legislature so as not to create another professional liability crisis in this program when it can be prevented.

COUNCILS AND COMMITTEES

Finalized FMA Legislative Priorities for the 1982 Legislative Session.

1982 FMA Legislative Program

- Require use of seat restraints in cars for infants four years of age and younger.
- Continue Community Hospital Education Council (CHEC) in essentially its present form.
- Modify current hospital cost containment law to eliminate tie-in with health planning and to simplify reporting requirements.
- Expansion of child abuse treatment team program to all Department of Health and Rehabilitative Services' districts.
- Make methaqualone unprescribable in Florida.
- Require that proof of licensure must be submitted with application for occupational license.
- Support for increased funding for the perinatal program, provided that suitable FMA policy is developed on this issue (now under study by the Council on Specialty Medicine).

COUNCIL ON LEGISLATION

Support for Legislation to:

Opposition to:

- Legislation authorizing unconventional cancer therapy (support Governor's veto of IAT Bill).
- Use of drugs by optometrists for treatment of disease.

- Access to hospital facilities or services by chiropractors.
- State funding of HSA's.
- Statutory recognition for chiropractors to certify disability of patients on equal status to M.D.'s and D.O.'s.
- Make Hospital Cost Containment Board rate regulatory or include physicians under jurisdiction.
- Funding for School of Osteopathy.
- Funding for School of Optometry.
- Licensure of Homeopathic Physicians.
- Licensure of Naturopathic Physicians.
- Mandatory insurance coverage for chiropractors.
- Mandatory insurance coverage for psychologists.
- Licensure of outpatient emergency clinics under the Hospital Licensure Law.
- Mandatory inclusion of chiropractic services in HMO's.
- Mandatory inclusion of chiropractic services in self-insurance programs.
- Prohibition against insurance companies using an M.D. or D.O. to do an independent exam of a patient to determine if continued chiropractic treatment is appropriate.

PLI Crisis

Resolution of the professional liability insurance problem in Florida remains a vital and top priority of the FMA. The report and recommendations of the Committee on PLI, adopted by the Board in October, 1981, (reprinted in the November issue of *The Journal*) contains an indepth analysis of the problem, as well as an outline of some of the actions that have been taken, as well as future efforts to resolve this critical problem in the most effective and expeditious manner possible. This report should be carefully reviewed by the county medical society leadership as well as each member of the FMA.

COUNCIL ON SPECIALTY MEDICINE

Sarasota Senior Friendship Center

Endorsed statewide implementation of a program of donor health services similar to that presently operating within the Sarasota Senior Friendship Center for health care for indigent senior citizens subject to the following criteria:

- That the physicians engaged, contracted, utilized or employed are participating on a strictly voluntary basis and do not receive any remuneration.
- That only physicians licensed under F.S. 458.317 or retired full licensed physicians be allowed to participate in this program.

- That the program provide screening to determine indigent eligibility.
- That the health care provided by these physicians to patients be limited to:
 - medical education
 - nutrition
 - self care
 - consultation and personal use of medications
 - health screening
 - diagnosis and referral.
- That care requiring surgery, hospitalization, multiple-testing, x-rays and complex long-term care be referred to a private practitioner.
- That the program only serve the medically indigent senior citizen.
- That the physicians participating under limited licenses do not seek hospital privileges.
- That the physicians participating in this program write only non-narcotic prescriptions.
- That these physicians practice with the approval of the local county medical society.
- That this program be under the supervision of the local public health department.

Schedule II Drugs

Approved a recommendation that FMA investigate a requirement of the Department of Professional Regulation that physicians furnish the home address on Schedule II prescriptions.

Physician Treatment of their Immediate Families

Approved that the FMA investigate the apparent problem that exists regarding a Department of Professional Regulation rule prohibiting physicians from treating members of their immediate family and to take appropriate action as needed.

Third Party Payers

Authorized FMA to conduct a study of third party payers who continue to review charges and send written correspondence to patients which sometimes include disparaging remarks in reference to excessive charges.

COUNCIL ON HEALTH CARE FINANCING

Workers' Compensation Fee Schedule

Reluctantly approved acceptance of an increase in the Florida Workers' Compensation 1982 Medical Services Fee Schedule to the 66 2/3 percentile of actual charge data as adopted by the Workers' Compensation three-member panel January 7, 1982. The Board also requested that the FMA President write to each member of the panel expressing the continued desire on the part of the Florida Medical Association to work with them in securing a more equitable fee reimbursement under the Florida Workers' Compensation 1983 Medical Fee Schedule.

Differential for South Florida Counties

Authorized a study to be undertaken to support the need for a fee differential under the Workers' Compensation Fee Schedule for Palm Beach, Broward, Dade and Monroe Counties.

Expressed highest commendation to Dr. Jim Richards, Chairman, and other members of the FMA Workers' Compensation Committee for their long and diligent efforts to help bring about an equitable level of reimbursement for physicians who participate in the Workers' Compensation program.

A historic review of the FMA's activities relative to the Workers' Compensation program and the Medical Services Fee Schedule can be found in the February, 1981 issue of *The FMA Journal*.

1982 Florida Relative Value Studies

Received a status report on the update of the Florida Relative Value Studies, approved retention in the 1982 RVS of modifiers 37, 38 and 39, for anesthesia, and approved modifier 22 for unusual services when the service(s) provided is greater than that usually required for this listed procedure.

Unauthorized Supplement

Directed that FMA take appropriate action to protect the 1982 Florida Relative Value Studies from unauthorized supplements that may be developed by specialty groups, third party carriers or governmental agencies.

Relativity Not Established

Requested the Committee on RVS to consider possible solutions to the problem of procedures being eliminated from the 1982 RVS that were included in the 1975 publication as a result of such procedures not being listed in the charge data, collected for use in updating the RVS, particularly as it relates to pediatric surgery. The Board requested that every effort be made to minimize as much as possible, the number of RNE's (Relativity Not Established) included in the 1982 RVS.

AD HOC COMMITTEE ON PHYSICIAN CHARGES FOR LABORATORY SERVICES

Reviewed a report and recommendation from the Ad Hoc Committee on Physician Charges for Laboratory Services regarding the actions of the 1981 FMA House of Delegates, in referring back to the Board for further study, Opinion 81-2 of the Judicial Council and Resolution 81-3 introduced by the Collier County Medical Society, and also Report E-1 of the Board of Governors.

Approved a recommendation to the House of Delegates at its 1982 Annual Meeting that the following policy be adopted with regard to physician charges for laboratory services:

"That physicians be permitted to charge a fair and reasonable fee for their professional services and that it is only feasible to charge to the patient the reference laboratory fees, however, the physician may charge in addition to the above a

reasonable charge for acquisition of the sample and a reasonable handling charge, and a reasonable charge for the ordering and evaluation of the appropriate diagnostic tests, the adjustment of therapeutic management as indicated and the discussion of findings and/or medical management.

(1982 Florida Relative Value Studies Code Numbers

90030
90040
90050
90060
90070
90080

Telephone Code Numbers

90013 — Telephone call for consultation for medical management: Simple or brief, E.G., to report on tests and/or laboratory results: To clarify or alter previous instructions: To adjust therapy.

99014 — Intermediate, e.g., to provide advice to an established patient on a new problem: To initiate therapy that can be handled by telephone: To discuss results of tests in detail.

99015 — Lengthy or complex, e.g., lengthy counseling session with anxious or distraught patient: Detailed or prolonged discussions with family member regarding seriously ill patient.)

"Further, it is recommended that in billing a patient for laboratory services which attending physicians perform for and on patients, the statement should provide information to show where such services were performed as well as an adequate description of the services provided using the descriptors in the 1982 Florida Relative Value Studies and the specific charges made.

"If it is not practical for the physician or patient, the attending physician may request the laboratory rendering the services to bill the patient directly."

Discounts

Reaffirmed the AMA and FMA's previous position:

"That it reaffirm the AMA and FMA's previous position that it is unlawful for any person to pay or receive any commission, bonus, kickback or rebate or engage in any split-fee arrangement in any form whatsoever with any physician, surgeon, organization, agency, or person, either directly or indirectly for patients referred to a clinic laboratory licensed under Chapter 483.245."

AMA DELEGATES

1981 AMA Interim Meeting

Received as information the report of the AMA Delegates activities and the actions of the AMA House of Delegates at the Interim Meeting, December 6-9, 1981, and requested that in keeping with the FMA Bylaws, this information be transmitted to the county medical societies and FMA membership.

Florida 8th Delegate

Due to an increase in the membership in Florida during 1981, the FMA will gain an additional delegate for 1982 bringing the total number of Florida delegates to eight. Election of the eighth delegate and alternate will be held at the FMA Annual Meeting in May and they will serve beginning with the AMA meeting, June 13-17, 1982. The two-year term will be retroactive to January 1, 1982, expiring December 31, 1983.

Candidates for Elective Office

The Florida delegation is continuing its activities in behalf of Dr. Rufus K. Broadaway, Miami, who is a candidate for election to the AMA Board of Trustees at the 1982 Annual Meeting. The active support of component county medical societies in behalf of Dr. Broadaway's candidacy will be greatly appreciated and a copy of his campaign brochure and biographical summary is being sent to all county societies.

House of Delegates Actions

Major issues considered by the House of Delegates included health care cost containment including pro-competition, consumer legislation and health coalitions; physician participation in Medicaid; affirmative leadership by physicians; voluntary peer review programs; continuing medical education rules. The following is a summary of the actions taken regarding these and other actions taken by the House.

1. Health Care Cost Containment

The House considered a number of reports relating to health care cost containment. The House endorsed participation in health care coalitions emphasizing the vital importance of meaningful physician participation in policymaking roles in addressing the vital issue of health care cost containment, and further noted the desirability of decentralizing cost containment efforts with major emphasis at the local level.

The House adopted two Board reports summarizing recent developments on pro-competition proposals and called for renewed emphasis by the AMA on monitoring the proposals currently before the Congress. The House expressed concern that the increase in health cost may intensify attempts to restructure, in an adverse manner, the current medical market place posing severe jeopardy to the existing system of free enterprise medicine.

2. Physician Participation in Medicaid

The House reviewed a proposal for a major revision in the Medicaid program which would have provided for tax credits or deductions to physicians for care of indigent patients in lieu of reimbursement. The House concluded that the concept was not appropriate at this time because of the difficulty in assessing legitimate charges as opposed to Medicaid payments; the introduction of the IRS into the reasonable charge determination; the probable public response to perceived increased financial rewards to physicians for treating the poor; and the anticipated unfriendly reception in Washington.

3. Affirmative Leadership by Physicians

The House applauded the address of AMA President, Dr. Daniel T. Cloud, and his call for physicians to exert affirmative leadership roles in addressing the increasing problem of health care cost and all of its contributing factors.

4. Voluntary Peer Review Programs

The House adopted principles for voluntary peer review including:

- Medical peer review is an organized effort to evaluate and analyze medical care services delivered to patients and to assure the quality and appropriateness of these services. Peer review exists to maintain and improve the quality of medical care.
- Peer review is a local process.
- Physicians are ultimately responsible for all peer review of medical care.
- Physicians involved in peer review should be representatives of the medical community and participation must be structured to maximize involvement of the medical community. Any peer review process must provide for consideration of the views of individual physicians, groups of physicians, or institutions under review.
- Peer review evaluations are based on appropriateness, medical necessity, and efficiency of services to assure quality medical care.
- Any system of medical peer review must have established procedures.
- Peer review of medical practice and the patterns of medical practice of individual physicians, groups of physicians, and physicians within institutions is an ongoing process of assessment and evaluation.

- Peer review is an educational process for physicians to assure quality medical services.
- Any peer review process must protect the confidentiality of medical information obtained and used in conducting peer review.

5. Continuing Medical Education Rules

The House adopted tighter standards for creating continuing medical education programs contingent upon subsequent approval of the Accrediting Council for Continuing Medical Education Handbook which is intended for use in evaluating national organizations, medical societies, academic centers, and hospitals that offer CME.

FMA Awards

Deferred until its March meeting, consideration of nominations for recipients of FMA Awards for 1982 including the A. H. Robins Award, Certificate of Merit, Certificate of Appreciation, and the Distinguished Layman's Award. County societies wishing to submit nominations should do so at the earliest possible date.

FMA JOURNAL EDITOR

Approved the President-Elect's nomination of Dr. Daniel B. Nunn, Jacksonville, for reappointment as Editor of *The FMA Journal* for the Association year beginning in May, 1982.

FMA INSURANCE PLANS

Authorized a modification in the accidental death and dismemberment plan sponsored by the Association to provide for an increase in the level of coverage for participants with no additional increase in premium. Physicians from \$150,000 to \$250,000; spouses \$50,000 to \$100,000; children \$10,000, no change.

CANCER CARE NETWORK OF FLORIDA

Approved FMA participation in the Cancer Care Network of Florida as a supporting member. The purpose of the non-profit organization is to provide a comprehensive, functional program of cancer care, and control the research in Florida through a cooperative consortium of Florida community hospitals, medical academic institutions, organizations and health care professionals.

MANAGEMENT

Approved the designation of Donald C. Jones, Executive Director, as Chief Executive Officer of FMA effective January 16, 1982. Dr. Parham will continue his responsibilities as Executive Vice President, which he plans to terminate in early 1984, except in a consultant capacity. Mr. Scotty Fraser was named Associate Executive Director. Mr. John Thrasher will continue as FMA Legal Counsel and serve as a consultant for Legislative Affairs. He will also continue his fiduciary responsibilities as Assistant Treasurer of FLAMPAC.

FLAMPAC

Voter Registration

Expressed support for the joint FLAMPAC/County Medical Society efforts to register physicians and their spouses to vote and to urge them to vote in the 1982 elections.

Applauded the achievements of FLAMPAC and the increase in members during 1981 and urged continued and expanded interest on the part of physicians and their spouses in the political process and active participation in FLAMPAC activities.

1982 ANNUAL MEETING

Golf Tournament

Approved a golf tournament to be held in conjunction with the 1982 Annual Meeting on Thursday, May 6, at the Bonaventure course.

Health Run

Approved the Fourth Annual Meeting Health Run (3.1 miles) to be held in conjunction with the Annual Meeting on Saturday, May 8.

Detailed information about the golf tournament and health run will be included in the FMA Annual Meeting *Briefs* which will be sent to the entire membership in the near future.



**BEWARE
THE
WINTER
WEATHER!**

RU-TUSS

Dispel the Clouds of Fall and

RU-TUSS[®]

TABLETS

Each prolonged action tablet contains: Phenylephrine Hydrochloride 25 mg
• Phenylpropanolamine Hydrochloride 50 mg • Chlorpheniramine Maleate 8 mg
• Hyoscyamine Sulfate 0.19 mg • Atropine Sulfate 0.04 • Scopolamine
Hydrobromide 0.01 mg • Each Ru-Tuss tablet acts continuously for 10 to 12 hours.

Symptomatic Relief of Sneezing and Nasal Congestion

Comprehensive decongesting, antihistaminic and anti-secretory reliever for patients with nasal, sinus and other upper respiratory irritation.

- Eases breathing • Reduces sneezing
- Reduces tearing • Dries the drip

One tablet b.i.d. gives round-the-clock relief to adults and older children (12 years and over).



RELIEVERS

Winter Respiratory Discomfort

RU-TUSS[®]

EXPECTORANT

Each fluid ounce contains: Codeine Phosphate 65.8 mg • (WARNING: MAY BE HABIT FORMING) Phenylephrine Hydrochloride 30 mg • Phenylpropanolamine Hydrochloride 20 mg • Pheniramine Maleate 20 mg • Pyrilamine Maleate 20 mg • Ammonium Chloride 200 mg • Alcohol 5%

Symptomatic Relief of Coughing with Nasal and Bronchial Decongestion

Full range symptom-reliever for patients with air way congestion in the upper chest as well as the nose and throat.

- Blocks the cough
- Loosens mucus
- Reduces sneezing
- Eases breathing
- Tasty, so it's easy to take



To Relieve the Symptoms of Winter Weather Upper Respiratory Distress

RU-TUSS[®] / RU-TUSS[®] TABLETS EXPECTORANT

RU-TUSS[®]

Tablets

DESCRIPTION

Each prolonged action tablet contains:

Phenylephrine Hydrochloride	25 mg
Phenylpropanolamine Hydrochloride	50 mg
Chlorpheniramine Maleate	8 mg
Hyoscyamine Sulfate	0.19 mg
Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours.

Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings).

OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdoses may produce convulsions and death.

ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension, hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.

HOW SUPPLIED:

Bottles of 100 Tablets

Bottles of 500 Tablets

Federal law prohibits dispensing without prescription.

NDC 0524-0058-01

NDC 0524-0058-05

DISTRIBUTED BY:

Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106

MANUFACTURED BY:

Vitarine Company, Inc.
Springfield Gardens, New York 11413

RU-TUSS[®]

Expectorant

DESCRIPTION

Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate	65.8 mg
(WARNING: MAY BE HABIT FORMING)	
Phenylephrine Hydrochloride	30 mg
Phenylpropanolamine Hydrochloride	20 mg
Pheniramine Maleate	20 mg
Pyriminamine Maleate	20 mg
Ammonium Chloride	200 mg
Alcohol	5%

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and expectorant preparation.

INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of upper respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rhinitis. Also, for the temporary relief of symptoms associated with hay fever, allergies, nasal congestion and cough due to the common cold.

CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an anti-hypertensive or antidepressant drug containing a monoamine oxidase inhibitor is contraindicated.

Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma and in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient should be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effect caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle or operating dangerous machinery (See Warnings). Caution should be taken with patients having hypertension, diabetes, hyperthyroidism and cardiovascular disease.

Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddiness, dryness of mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension, hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, and insomnia. Overdoses may cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and even convulsions.

DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours, not to exceed 10 teaspoonfuls in any 24-hour period.

Children 6 to 12 years of age: $\frac{1}{2}$ the adult dose, not to exceed 6 teaspoonfuls in any 24-hour period. Children 2 to 6 years of age: $\frac{1}{2}$ teaspoonful every 4 hours, not to exceed 3 teaspoonfuls in any 24-hour period. Children under 2 years of age: Use as directed by a physician.

HOW SUPPLIED: (16 fl. oz.)

Pint Bottles

Federal law prohibits dispensing without prescription.

NDC 0524-1010-16



Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106
Pioneers in medicine for the family

Our Debt Is Great

This month *The Journal* once again spotlights the work of the FMA Auxiliary. It is fitting that a special edition should be set aside both to honor the Auxiliary and to educate us all as to the depth and breadth of their involvement in medical affairs in Florida.

The debt that we physicians owe to our spouses is enormous. Were it not for their early financial and psychological support, many of us could never have become physicians in the first place; yet I am sure many wives look back on the long hours and poor pay and housing of the years of medical school and postgraduate training as being among the "good years". The subsequent years of increasing responsibility and commitments that come with a growing medical practice are in many ways harder for the doctor's wife. She often finds herself in the unenviable position of having to raise a family almost single-handedly, while serving as cook, housekeeper, and social secretary to a husband who is bound to the most frustrating of mistresses — the practice of medicine. Medicine has first call on his time and energies and rewards him with satisfaction and prestige, while at the same time it tends to keep him away from those who most deserve to share in those rewards. The fact that so many medical wives can withstand such pressures and continue to provide a haven of love and support is in itself a tribute to the strength of these remarkable women.

That these women have gone beyond simply providing a haven and have actively set out to help us in our work is attested by the many projects and programs outlined in this month's *Journal*.

At the local level, the auxiliaries have served our communities and represented us well in a wide variety of health-related public service projects. At the state level they have joined in further good deeds through such projects as the International Health program. They have led the way in support of medical education both through the Florida Medical Foundation and its contributions to our three state medical schools and through projects to support AMA-ERF. They have provided much support and impetus to the development of the state's Impaired Physician Program.

Perhaps the greatest contribution of the Auxiliary as a group has come in the area of political action. As it has become increasingly necessary to become involved in the processes of government, we have relied heavily on the Auxiliary to provide much of that involvement. From the initial steps of campaigning for politicians who will give our cause a fair hearing to the final process of monitoring and providing appropriate input into the consideration of specific bills before the Legislature, the Auxiliary has become the mainstay of our political action program.

Let us, therefore, take this opportunity to salute the FMA Auxiliary. We owe them much, but we recognize this debt and would repay it with love and appreciation.

Henry L. Harrell Jr., M.D.
Assistant Editor
Ocala

Who Needs an Auxiliary?

To the title question, I as a doctor respond with a resounding, "We do!"; to those cynics who will inevitably respond, "why?", the following is my answer.

The Auxiliary members, collectively and individually, are the best things we have going for us. When it comes to public relations they undo the damage we do to ourselves. When doctors take a stand on a public question, it is all too often interpreted as reflecting self interest even though the good for society should be self evident. Conversely when a doctor is acting in a totally altruistic manner, professional integrity and allegiance to principles of ethical behavior prevent this being published afar. Additionally, it is a fact of medical practice that when a physician is attending a patient, that patient is entitled to 100% of his or her attention, the amount of time is not prescribed in advance, and additional patients are waiting with similar inestimable time entitlements. Thus, although too often used as an excuse, it is true that most physicians have little time left over from their patients for other activities.

The term, auxiliary, is defined as, "giving assistance or support, aiding, helping, supplementary". Anne Swing stated in last year's Special Auxiliary Issue of *The Journal*, "We are highly motivated to uphold the Florida Medical Association, respect its principles, and help

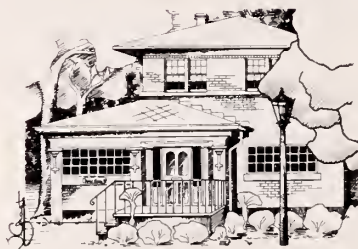
promote its interests and programs. Auxiliary is firmly dedicated to community service and the continued improvement of health standards in our country".¹

As individuals we must love and cherish our auxiliaries; they are our spouses. They make our lives meaningful and worthwhile, but now I am saluting them collectively in their organizational role. As community volunteers they truly work unceasingly to make life better for society's families and individuals and they approach these efforts with such sincerity and sensitivity that their motives can be impugned by no one.

The Auxiliary accomplishments are set forth in this issue, factually, descriptively, and modestly. Take note and give thanks that they are with us. We don't merely need them; we'd be much less than complete without them.

*James K. Conn, M.D.
Assistant Editor
Tallahassee*

¹ Swing, Mrs. Fred P. "Auxiliary in Action" J. Fl. Med. Assoc. 68:3 163-164



easy to take



250-mg Pulvules®



Oral Suspension

250 mg/5 ml
100 and 200-ml
sizes

125 mg/5 ml
60, 100, and
200-ml sizes



Pediatric Drops

100 mg/ml
10-ml size

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cephalexin

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to the profession on request.



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DRAMATIC NEW CLINICAL PROOF*

In the treatment of impetigo—

- **100% cure rate with Tegopen®** (cloxacillin sodium)
- **only a 60% cure rate with penicillin V-K**



As seen on admission



After one week of penicillin V-K therapy



Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. No treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

Brief Summary of Prescribing Information

TEGOPEN®
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular.

(12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® (cloxacillin sodium)	Given penicillin V-K
<i>Staphylococcus aureus</i>	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
<i>Staphylococcus aureus</i> and <i>Streptococcus pyogenes</i>	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth	(14 patients)	9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic <i>Streptococcus</i>	(1 patient)	0	1
TOTALS:	102 patients	52 patients	50 patients

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported

the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus*, 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes*, and 1% beta-hemolytic *Streptococcus*.†
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.

- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

†The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®

(cloxacillin sodium)

**—effective therapy for staph infections
of the skin and skin structures**

WARNING:

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:

The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:

Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose

stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:

Adults: 250 mg. q. 6h.

Children: 50 mg./Kg./day in equally divided doses q. 6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

W.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

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About the Cover

This month's cover is symbolic of the busy and complicated paths of involved Auxilians. Mrs. James A. (Anne) Winslow of Tampa, a gifted artist and photographer and a member of the Hillsborough County Auxiliary, composed the cover. Anne was a logical choice to apply her talents to the cover for this Special Auxiliary Issue.

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussions of medical history and ethics; and articles dealing with socioeconomic, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to Daniel B. Nunn, M.D., Editor of *The Journal*, Florida Medical Association, Post Office Box 2411, Jacksonville, Florida 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal*.

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

Abstract. All scientific manuscripts should include a 150 word, maximum length, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given.

References. The following minimum data should be given:

names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request".

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication".

When received, the senior author will be sent an acknowledgement of receipt and a copyright agreement which must be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

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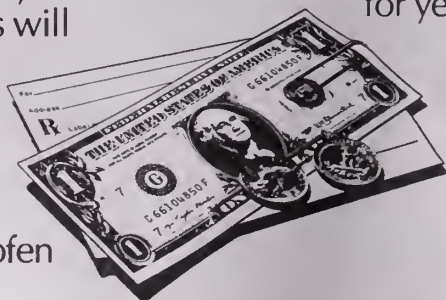
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Original research by The Boots Company Ltd., of Nottingham, England, developed ibuprofen.

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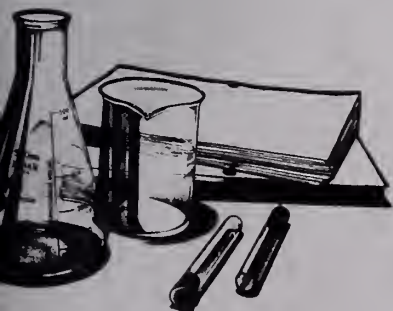
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INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

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CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see **WARNINGS**).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see **CONTRAINDICATIONS**). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the **ADVERSE REACTIONS**.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS

Incidence greater than 1%

Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4% to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see **PRECAUTIONS**).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see **PRECAUTIONS**). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecostasia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease. Suggested dosage 400 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain. Do not exceed 2,400 mg per day.

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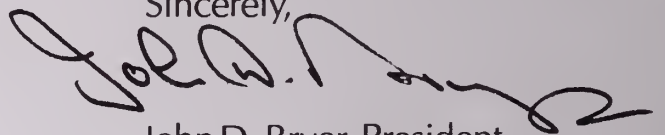
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

FEBRUARY 1982
VOL 69 • NO. 2

Guest Editor's Introduction Auxiliary Comes of Age

Mrs. LaVere G. (Mae) White

The Florida Medical Association Auxiliary is grateful to the FMA for the opportunity to present its point of view in this Special Issue of *The Journal*. We are proud to be affiliated with a progressive professional organization with an impressive past and a promising future.

As changes have taken place in the field of medicine, both scientific and political, the FMA has kept up with the times. The Special Historical Issue of *The Journal* (August 1981) described the many changes in the practice of medicine in Florida over the past 63 years. The past is of interest, not just for the sake of history, but because it is the birthplace of the future. From a knowledge of the past and an awareness of the changes taking place in society, we gain a sense of continuity as we prepare for the future.

The Auxiliary, like FMA, is also a dynamic organization which constantly reflects the changing times. Its mission and image are quite different from what they were years ago, and appropriately so. At one time, we were mainly concerned with "cultivating friendly relations and promoting mutual understanding among the family of medical doctors". Although that is still a pleasant "side effect", we do a lot more than that today. We are now a modern, pertinent and mature organization. To illustrate these points, we have chosen "Auxiliary Comes of Age" as our theme for this Special Issue.

We hope you enjoy the articles written by Auxiliary members found in these pages. I am deeply grateful to the members who spent their precious time writing them. The authors approach the theme from different points of view, each in her own way, ranging from serious to humorous and from abstract to concrete. The articles cover a time span of many years from "An Auxiliary Legend" which is the story of a doctor's wife in Florida in the late 1800's to "Challenges For the Future". They cover the outlook from different levels — national as well as county and state.

The time has come for Auxiliary to take its place as equal partners with physicians in their efforts to improve the health and well-being of all citizens. Women now have the option of many roles as a result of society's changing attitudes. The new self-image and expertise of our members must not be wasted and need not be in today's society. The medical profession must use us or lose us. We look to a strong union with organized medicine and a bright future full of excellence for us both, as we work together.



Mrs. L. G. (Mae) White of Fort Lauderdale, Guest Editor of this Special Auxiliary Issue of *The Journal*, has served in various capacities with the Florida Medical Association Auxiliary for the past 12 years. She originated "The Beeper", FMA-A's newsletter, and was its Editor for four years.

Reaching for Excellence

Mrs. Francis C. (Ruth) Coleman

The Auxiliary this year has a goal of the pursuit of excellence. In pursuing this goal, we are at the same time seeking adulthood. Adulthood should be accompanied by maturity. Maturity, adulthood, excellence — all are states we are striving for. As we reach toward these goals, we are attempting to do good things better, to eliminate those things which no longer are pertinent, and to see new things that should be part of our program.

In looking back over the development of the FMA Auxiliary through its 50 plus years of existence, we see that it has constantly revamped its goals and in doing so has passed through many stages of development. These stages of development are similar to those of individuals.

In the years my own children were growing up, Gesell and Ilg's books on child development were always near at hand. In these they described the several plateaus that are reached in a child's life when his emotional, physical and mental development are such that he "has it all together". In order to reach the next plateau, he or she must then go through the process of breaking up, reorganizing and putting together again on a new level.

Stages of Development

Now we are realizing that adults, too, must go through predictable stages of development. Two of several recent books on this subject are *The Seasons of A Man's Life* by Daniel Levinson and *Passages* by Gail Sheehy. Levinson shows the pattern of a man's cycles and Sheehy's "passages" are the traumas one must go through in moving from one stage of development to another.

The Auxiliary has successfully passed through the stage of infancy, when its goals were primarily social; through childhood, as it began to reach out into the community; through adolescence, as it felt the conflicts between social and service oriented priorities; through

early adulthood, as our direction became clearer and we focused on becoming a more meaningful part of the FMA team. Now once again we are in a passage as we break up, put together and reach upward in striving toward full adulthood.

The ideal of maturity may be expressed as "the real person", the "mind alive", the "self-actualizing person", the "fully functional person", and the "healthy personality". Certain characteristics are present in nearly all of the above. They are faith, courage, integration of personality, a love to share, self acceptance and joy. Are any or all of these qualities appropriate for our Auxiliary?

Yes, our Auxiliary needs to have faith in itself. Faith gives the ability to roll with the punches, pick up the pieces and start over; it gives the power for "renewal and come back". It gives a feeling that life has worth and meaning.



Mrs. Francis C. (Ruth) Coleman, President of the Florida Medical Association Auxiliary and author of the accompanying article, is shown (left) at the installation of Hillsborough County Medical Association Auxiliary officers last year. Also pictured are Mrs. Calvin H. (JoAnne) Mitchell (center), President of HCMA-A; and Mrs. Robert H. (June) Owrey, Vice President.

The Author

MRS. FRANCIS C. (RUTH) COLEMAN

Mrs. Coleman resides in Tampa and is President of the Florida Medical Association Auxiliary.

Seeking the Truth

The Auxiliary needs the courage to seek the truth. It must continually re-examine the familiar, develop new ideas, learn new skills, but keep our heritage intact.

The Auxiliary needs to be integrated and cohesive. It should have unity with a common pattern of thought and feeling that gives coherence to everything it does.

The Auxiliary should share its love with others. To love means to give; to give requires a maturity of self feeling. Our members must be capable of warm relationships with each other and toward those who benefit from our projects.

The Auxiliary should accept itself. It must recognize both its strengths and limitations and use its resources to their maximum potential. It should be able to look at itself objectively, even to laugh at itself at times.

The Auxiliary needs to know joy. It needs to appreciate again and again the basic goodness of life with pleasure and wonder. Wonder indicates aliveness, interest, expectancy and responsiveness. It is the opposite of cynicism and boredom. Joy, rather than happiness, should be our goal, for joy accompanies self-fulfillment and service to others.

Elements of Maturity

These basic elements of maturity can and must be pursued within our organization if we are to climb onto the plateau of adulthood and excellence.

All of these qualities can be demonstrated as we work as partners with our spouses in community service, political action and legislation; as we become active participants in programs such as that for the impaired physicians; as we provide leadership in addressing the special problems that arise in medical marriages; as we promote understanding and support for the aging; as we become leaders in dealing with the problems of drug usage in our schools and with teenage pregnancies; as we expand our fund raising for AMA-ERF, International Health and Health Occupations scholarships; and as we work for good health and safety for all children.

When Florida's representatives go to the several meetings the AMA Auxiliary holds in Chicago each year, we have the opportunity of measuring ourselves against auxiliaries of other states. Florida rates among those at the top. In our pursuit of excellence, we are getting it all together. We are shaping up; we are reaching for the next plateau — full maturity.



FMA-A President Ruth Coleman presents Health Occupations Students of America scholarship award to Terri Kuhns, National Honor Student.

The FMA Auxiliary: Importance of Membership

Mrs. Daniel B. (Gloria) Nunn

In contemplating the importance of FMA Auxiliary membership, it seems appropriate to begin with a few explanatory remarks concerning the makeup and purpose of the Auxiliary. The FMA Auxiliary is defined as a volunteer, health-related, community service organization composed of the spouses of FMA members.

General objectives of the Auxiliary may be summarized as follows: (1) to assist the FMA in programs designed to promote better health care for the people of Florida; (2) to coordinate the activities of component county medical auxiliaries; (3) to foster health education and support health-related charitable endeavors; and (4) to receive and disburse gifts for implementation of the aforementioned goals.

By means of excellent guidance, dedication to ideals, and incessant hard work the FMA Auxiliary has made numerous meaningful contributions to both community welfare and the medical profession. The Auxiliary has been particularly effective as a strong public relations arm for the FMA. Over the years, the FMA Auxiliary has steadily grown in stature and influence to the extent that "Auxiliary power" is now recognized as one of the FMA's most powerful resources. Consequently, the Auxiliary has been afforded an increasingly responsible role in FMA activities. A notable example is the fact that auxiliaries currently serve on four important FMA committees or boards (the Committee on Legislation, Committee on Impaired Physicians, FLAMPAC Board of Directors, and the JFMA Board of Consulting Editors).

The Author

MRS. DANIEL B. (GLORIA) NUNN

Mrs. Nunn is President Elect of the Florida Medical Association Auxiliary and lives in Jacksonville. Her husband is Editor of *The Journal*.

In order to meet effectively both present and future challenges, the FMA Auxiliary must continually strive to achieve and maintain a strong membership. With this in mind, it should be pointed out that the current roster of approximately 5,000 members represents a relatively small percentage of the total FMA membership (about 14,000). Obviously, there is considerable room for improvement; hence, efforts to enhance membership need to be regarded as a high priority item among FMA Auxiliary goals. Since there is a great deal of competition for volunteer workers, FMA Auxiliary membership drives should emphasize the importance of membership while also portraying the Auxiliary as a true example of "voluntarism at its very best!"

The Auxiliary is grateful for the support and guidance of the FMA. Together, we have made great strides, and we must continue to do so. Rest assured that auxiliaries want to be equal partners in the struggle to promote healthful living for a happier tomorrow.



Mrs. Cilio (Carol) Guerriere welcomes Mrs. Jack (Marvse) Parrino as a new member of the Hillsborough County Medical Association Auxiliary.

The Auxiliary Volunteer: A Special Breed

Mrs. Rod M. (Lita) Martija

For some reason, the medical spouse is often perceived as the lady who sips Perrier at a fund raising dinner, or cocktail party, wrapped in furs and dripping with insured jewelry.

The conception is she is either the smart nurse (how else did she land a doctor for a husband?) who works at her husband's office to screen calls and handle the books, or she is the well-dressed housewife who jogs at the crack of dawn, attends Auxiliary meetings to kaffee-klatsch with friends in designer clothes, plays golf with cronies at exclusive country clubs, swings tennis racquets and lolls in backyard saunas to get to a size 6, then trots off on weekends with the kids and a husband (who's most likely not "on call") to their oceanfront condo to relax. That, of course, does not count the three months of each year spent skiing in Aspen or touring Europe.

To correct this distorted image will require more than just this article. There's nothing wrong with affluence, or living like one is, if one can afford to, or with being preoccupied with muscle toning and revving up the circulation to keep the old ticker going. After all, this is the same generation that spends \$3 billion in health foods and \$1 billion in sports shoes. But it certainly is a terrible injustice to portray the medical spouse as "doing mostly nothing but . . ." If there's anyone deserving of a better and more accurate portrayal, it is the doctor's spouse; minus the "fur and jewelry", with it, or despite it. So next time you meet a medical spouse and an auxilian, or talk to one, listen and look a little closer. The metamorphosis might have been a little slow, but the image, thank God, is changing!

The Author

MRS. ROD M. (LITA) MARTIJA

Mrs. Martija, a resident of Longwood, is Editor of *The Beeper*, the newsletter of the Florida Medical Association Auxiliary.

Male Auxilians

The AMA Auxiliary recorded some 65 male medical spouses joining the medical auxiliaries nationwide in 1981. Although that would seem to make us a mixed group of Perrier-sippers, one thing is clear: some medical spouses do forsake the fur and jewelry.

A recent talent search conducted by the FMA Auxiliary showed we're not only smart, we've got brains. Why else would our husbands (or wives) land us? It seems our special ilk is really a conglomerate of talents in fields ranging from health, science, education and engineering to music, theatre, arts, law, social work, public relations and journalism.

If the survey failed to identify some of our other professions, it must be because some medical spouses are busy writing books on Indian artifacts or archeology, or some such intimidating subjects, or working as elected members of the county school boards and as appointees to the Environmental Regulations Committee and the Ethics Commission of this state, among other things.

But the survey identified a common preoccupation: individually, or as members of the medical Auxiliary service network, we are quietly and effectively assuming active and visible roles in community activities. The medical spouse is a caring, concerned, and knowledgeable volunteer. The medical Auxiliary, with resources gained in its 55 years of existence, has created a special breed of community leader. It has spawned a service network, based in 30 counties and counting almost 5,700 members, rendering vital services incalculable in terms of dollars and cents in areas of health care and public health education, social welfare, international health, legislation and political action. It raises funds for health career scholarships, medical research and other charitable causes. It is involved in advocacy and support group programs. Its service arm, the medical auxilian, not only effectively tackles all these volunteer responsibilities, but continues to seek new directions where a positive response can be given to an unmet need in the community.

Public Health Education

The Auxiliary conducts many public health campaigns. Our goal is preventive and educational: to help people develop positive attitudes about health, encourage them to adopt positive health habits, provide them with information to enable them to acquire skills to take care of themselves, and make good health-related decisions in their lifetime. Health care cost is also a foremost concern of public health education; it took nearly \$1 out of every \$10 that Americans spent last year. National health bills in 1980 rose the most in 15 years, according to reports, and hit some \$247 billion, or 9.4% of the Gross National Product.

The message is being brought before women's clubs, churches, youth groups, schools, and where most people congregate.

In Orange County, auxiliaries took "Mr. Humpty Dummy" to 3,000 6th graders last year to demonstrate graphically the hazards of smoking.

"Mr. Dummy" is a smoking machine in the shape of a humpty dumpty doll which, when manipulated, "smokes" cigarettes and accumulates tar and nicotine in his "lungs". The program includes a film that can scare the daylights out of a three-pack-a-day smoker. Some 18,000 children have been reached since the program began in 1976.

In Hillsborough County, it is "Betsi" helping auxiliaries teach Breast Self-Examination to women and teenage girls in an enclosed, private corner of a crowded mall in Tampa Bay. Betsi is a plastic model of a female breast with built-in "lumps".

The importance of this program is underscored by frightening statistics: Nearly one out of 13 American women will develop breast cancer at some time during their lives. The breast remains the foremost site of cancer incidence and death among women 40 to 44 years old. The disease, if detected early by BSE or regular professional checkups, can be cured or controlled. Ninety percent are being discovered by the women themselves through breast self-examination, and auxiliaries are intensifying their campaigns across the state. Methods used and tools of instruction vary. But the message is clear: Make BSE a regular monthly habit, the life you save is your own!

"A Child Is Born"

Volusia County auxiliaries lead 6th graders on a tour of a Health Science Exhibit called "A Child Is Born" which represents the students' only approved form of sex education in the public schools. Exhibits include a five-month-old "fetus", and an "ectopic" pregnancy mounted in plexiglass.

Clay County auxiliaries manipulate delightful puppets called "Kids On The Block" for the Association of Retarded Citizens of Clay County. The puppets are little "people" with various forms of handicaps which are explored during the entertaining shows.

The Education Committee of South Broward County operates a Reading Center staffed by volunteer para-professional teachers who completed in-service training in remedial reading techniques. They began in 1973 with 21 volunteer medical wives, one school and 10 primary school children. Today, ten elementary schools in South and South Central Broward are participating, and 280 students are receiving instructions. With the strong and supportive role of the Auxiliary, the community has provided a dedicated group of 58 volunteers who donated 11,081 hours of work.

In Sarasota County, the Auxiliary conducts G.E.M.S. (Good Emergency Mother Substitutes) Courses which include First Aid, Crime Prevention, Creative Play, Infant Care, and Fire Safety. In Orange County they use auxiliaries who are certified CPR instructors to teach cardio-pulmonary resuscitation techniques and the Heimlich Maneuver for choking victims.

They also assist the health department in reminding parents to have their children immunized against childhood diseases. Florida, through its Compulsory Immunization Law for schools, requires an accurate and complete record of each student's immunization. As a result of the 1977 Childhood Immunization Initiative and the 1978 Measles Elimination Initiative, measles is expected to be eliminated in the United States this year. The Center for Disease Control has also announced that rubella and the birth defects associated with it are headed for a record low; that German measles can be eliminated in the United States; and rubella and congenital rubella syndrome can also be wiped out if we're willing to put forth a little more effort.

Child Abuse and Neglect

The National Center of Child Abuse and Neglect reports some 2 million children a year abused, including 6,000 fatalities. In Florida, 26,800 reports of child abuse were received last year involving 54,229 children.

The medical Auxiliary has alerted the counties to explore areas of involvement in this epidemic by legislative advocacy, fund raising for existing programs, developing treatment programs, providing volunteer services to agencies, establishing self-help chapters for abusive parents, making homes available as emergency foster homes, and lay therapy training programs.

Auxiliaries responded and made themselves available as volunteers. Pasco County sent two Auxiliary members to join their county's Child Abuse Task Force.

Clay's Child Abuse Project recently got off the ground as the "Children's Haven of Clay County, Inc.", a therapeutic residence for abused and neglected children. The organization and responsibility will pass to a working board of directors in which the Auxiliary will sustain a permanent member. They will also continue to give it financial support.

Lee County auxiliaries support a Crisis Nursery for abused children. West Broward collects children's clothing, toys, shoes, blankets, beds with side rails, and other items for "kids in distress", while South Broward collects sheets and supports "women in distress", a crisis house for battered and homeless women and their children.

There are many other supportive and public awareness programs being run by counties for child abuse.

Child Safety

Auto accidents kill more children — about 2,000 each year — than polio, diphtheria, mumps and rubella. Experts believe that it is the number one killer of children under four today, and that 90% of deaths and 70% of injuries resulting from car crashes are preventable by safety restraints in automobiles.

The American Academy of Pediatrics has given its first priority to promoting the use of child safety restraints and seat belts in cars. It has been announced it will form a national coalition of child health groups and medical specialty societies to mount a national campaign for this purpose.

Tennessee was the first state to make it mandatory to have car seats for children. So far, eight states have followed with stringent Infant Car Seat laws.

The Auxiliary has included Child Safety as one of the important concerns of its expanded Health Education Committee. Counties are now in the process of exploring the problems and the particular needs of their community in this area.

The Impaired Physicians Program

Since January 1981, more than 40 physicians have been through this advocacy and non-punitive support program for physicians who have alcohol and drug dependency problems. Efforts are now directed towards outreach and intervention. Workshops are being held to train physicians to become intervenors for their colleagues who have problems.

Substance Abuse

Alcohol and drug dependency is a crippling menace to our society today. It afflicts children and adults of all

ages. Its victims cut across all economic lines and educational levels. Sometimes, it creeps too close to home.

Auxiliaries responded to this problem through trained volunteers who lead discussion groups, give lectures, bring exhibits and show films to school children on drug awareness; through workshops which explore its medical and psychological aspects, its legal responsibilities, as well as its impact on the family relationships; and through supportive and advocacy programs such as the Impaired Physician program of the FMA and the medical Auxiliary for its own members and their families.

County auxiliaries also raise funds to give financial assistance to existing agencies offering rehabilitation programs.

Aging

It was not Ponce de Leon's mythical fountain that did it, although he pursued this magic water that supposedly restores youth from Bimini to Florida. It was the great strides that modern medicine took that increased our life expectancy, and created the vastly growing number of senior citizens this side of retiree's paradise.

Government experts project a shortage of younger workers in years ahead but no major programs are being planned to encourage older Americans to stay on the job and keep busy. Meanwhile, boredom, the feeling of being useless, unneeded and unproductive, is disabling our seniors today more than old age or any other disease.

The plight of our aging citizens is a new concern of the Auxiliary. Some programs, mostly supportive, have been started: auxiliaries visit, write and read letters for them, assist them with transportation to and from stores and to and from doctor's appointments, include them in home activities, and keep in touch with them by phone.

According to Mrs. Fred Swing, the Auxiliary's State Chairman on Aging, this is the year of study and data gathering. More one-to-one programs are being planned.

Seminars and Workshops

The Auxiliary holds seminars and workshops to disseminate information and stimulate interest in timely and pertinent subjects; and to train members, parents, professionals and other citizens of the community to better handle and understand their volunteer responsibilities.

Broward, for one, has a series of "Total Child Seminars" about issues on child development and education. Their eighth, which will be held this year, is on "A Child's Perspective: Growing Up in Violent America". It will address the problem of raising children in an environment where violence seems to have taken a firm foothold in our way of life.

Orange and Palm Beach Counties have "Worry Clinics" and sessions on subjects that range from stress, to marriage, to finances, to coping with grief. Bay County, in a recent workshop, explored the options for women of Northwest Florida which includes physical and mental health, careers and working, and impact of religion on a woman's view of herself.

Fund Raising

Raising money for charitable and health-related causes is an ongoing activity for the county auxiliaries. Scholarship grants are awarded to students pursuing health careers. Donations are given to human services agencies. Thousands of dollars are channeled to AMA-ERF for medical research, better equipment, and additional faculty. The Auxiliary's helping hand reaches out even beyond our territorial boundaries to support medical clinics of the impoverished third world, to bring South American children to this country for reconstructive surgery, and to assist economically disadvantaged migrant farm workers.

As a fund raiser, the auxilian is a unique breed. Social activities for medical families become benefit projects. Items which they themselves donated are auctioned. Handcrafted items are sold at bazaars.

International Health

There are two beneficiaries of funds auxiliaries raise for international health. First, we support the nonprofit group of volunteer surgeons and medical personnel called INTERPLAST which provides free reconstructive surgery to children from abroad who are disfigured by congenital birth defects or accidents. The second is the Florida migrant worker.

The Rural Manpower Office of the Florida Department of Labor and Employment Security in this state estimates the migrant worker population at close to 76,000, exclusive of those who are unemployed. There are 4.7 family members on the average per migrant; therefore, we have a sizable number who live in sub-standard housing, whose occupation is considered the third most hazardous in the nation, and whose life expectancy is 20 years less than the average American.

Because they are a proud although impoverished group, fewer than 10% receive public assistance; 60% of households earn less than \$3,000 a year; their infant mortality is 2½ times the national average, incidence of TB

and other respiratory diseases is from 200% to 300% above the national average; 50% had no formal schooling and cannot read or write.

The plight of these people is an ongoing concern of the Auxiliary. Palm Beach County collects toys for their children, and canned goods for their food closets.

Other Special and Supportive Programs

There are many other areas of involvement that Auxiliary members dedicate themselves to. Marion and Clay auxiliaries attend Special Olympics games to support the efforts of physically and mentally handicapped entrants to this special athletic competition with emphasis given to the joys of their having tried. Pinellas provides volunteers to a Free Clinic who help out with clerical work. Collier sponsors a volunteer interpreter for the emergency room. Lee has an ongoing project called "Coping With Grief" which is a support group consisting of a council of professionals assisting area residents with grief-related problems.

Volunteerism

FMA President, Sanford A. Mullen, M.D., has called for "greater involvement" by Florida's physicians in community service. The federal government, intending to reduce its support from many of the human services, will return to local governments the responsibilities to answer the social, health, and educational needs of their residents. According to reports, federal aid to Florida will be chopped by at least \$340 million. Our State government, in turn, declared that it intends to cut services rather than impose additional taxes to raise revenues. Communities must pick up and maintain social programs that the government once kept afloat. The call for volunteerism will, by sheer necessity, be louder, more urgent.

There's a special breed of volunteers that will answer that call, as they have always done in the past. It is a group who quietly give of themselves, their time and energies to serve their neighbors and respond to the needs of their communities — the same people you see sipping Perrier at fund raising affairs, and jogging before the sun rises, and who may or may not be spangled with jewelry and covered with furs — the medical spouse, the medical auxilian who is, finally, being recognized and identified as a partner of organized medicine in meeting their collective civic responsibilities to the public.

Community Leaders



Mrs. Arthur (Jane) Eberly, Broward County President; and Mrs. Joseph (Bea) George, Dade County President.



Marilyn LeVine, Pinellas County; and Barbara Mintz, Lee County.



Jeanine Hogue, Alachua County President; and Pat Voorhis, Bay County President.



Jo Ann Mitchell, Hillsborough County President; and Helen Holmes, Escambia County President.



Linne Goberville of Broward County screens a boy for scoliosis.



Pat Ackourney of Broward County conducts a screening for hearing defects.



Donna Wendland, Magda Ginnis and Betty McCarthy of Broward County conduct a vision screening test.



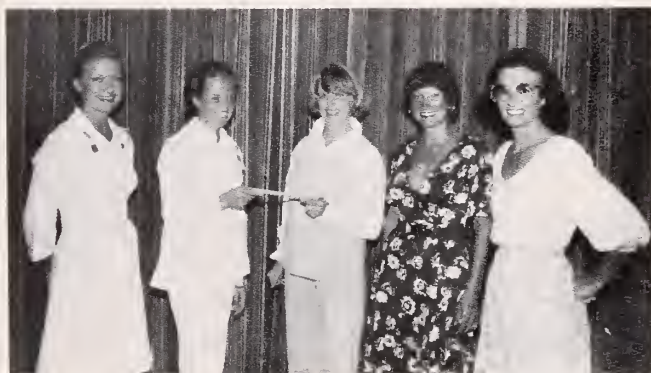
Mrs. Albert (Judith) Tawil and Mrs. Ferdinando (Margaret) Vizzi at International Health Bazaar, Fall Conference.



Mrs. William Toruno, Mrs. Walter Laude, Mrs. Delfin Biglete and Mrs. Danilo Aquino at International Health Dinner-Auction in Polk County.



Escambia County Volunteers Sandra Holman and Elaine Clifford working at Sacred Heart Children's Hospital.



Jan Stults, Magda Ginnis and Stephanie D'Alessandro of Broward County present a check to nurses for the North Broward General Hospital Pediatric Ward.



Health Careers Day sponsored by Hillsborough County Medical Association Auxiliary.



Dawn John of Escambia County shows a breast self-examination film to some high school students.



Jo Ann Mitchell of Hillsborough County demonstrates breast self-examination in a shopping mall.



Mrs. Richard (Lynn) Brunelle of the Hillsborough County Medical Association Auxiliary, conducts a drug abuse program in an elementary school.

Impaired Physician Update

Mrs. Frederick J. (Marybeth) Weigand

Overheard at a recent Workshop on Impaired Physician Intervention: "How could you do that? . . . Just leave your office in the middle of the day with a waiting room full of people? . . . Ask your staff to rearrange a tight schedule for the next couple of hours — just like that?" That question was put by one doctor to another as they walked down the hall. The second doctor hesitated, turned to him and softly responded: "Because a colleague of mine was in a crisis — as real a crisis as if he had been in cardiac arrest and needed CPR. How could I *not* go to him immediately? It was an emergency!"

The two physicians were among those attending a workshop sponsored by the Florida Medical Foundation Committee on Impaired Physicians. The workshop was part of a series of seminars designed to encourage M.D.'s to expand their knowledge of the disease of addiction and how it particularly affects the physician population. It was also designed to give them the necessary skills in the process of intervention with a colleague suffering from the disease.

The individual asking the question, "How could you?" was breaking through his own professional and educational defenses at this workshop; and, in the process, availing himself of a wonderful learning experience, one to one, with his colleagues. He was not only receiving instruction about the disease of addiction but also was learning that it takes courage, commitment and caring as a human being to be involved in the Florida Impaired Physician's Program. He was probably a little overwhelmed at the depth of commitment around him. And so the question, "How could you leave your office in the middle of the day like that?" . . . actually became "How could you risk reaching out to a fellow physician at such a personal level and be willing to pay the price of rejection?" The answer, of course, is simple.

The Author

MRS. FREDERICK J. (MARYBETH) WEIGAND

Mrs. Weigand, of Deltona, is Chairman of the Impaired Physicians Committee of the Florida Medical Association Auxiliary and is a member of the Florida Medical Foundation's Impaired Physicians Committee.

Taking the Risk

Caring, informed physicians take the risk every day because their colleague is sick and in a very real, life threatening crisis because of it. Period. They can do no less.

Florida physicians who have attended the workshops offered by the FMF Committee on Impaired Physicians are realizing this. Workshop critiques have elicited such responses as: "I learned I deal with the disease of alcoholism in my practice more than I realized" . . . "I was particularly interested in learning the techniques of intervention" . . . "I learned a great deal about the early recognition of the disease of addiction that I never knew before."

Until recently, precious few educational opportunities to learn about the disease of addiction have been seized by most doctors. Many continuing education hours are spent updating their knowledge of the physical results of the disease, but not the disease itself. Treatment of addiction can be frustrating and time consuming; ask any practicing physician in a busy office. Early identification and intervention is the simplest and most successful method of treatment as with any sickness. This identification and intervention process — one physician to another — is the very heart of the Impaired Physician Program. This *heart* must have continuing education, support and involvement throughout the medical and Auxiliary community to continue to beat steadily and grow stronger. And it will.

Auxiliary Support

Auxiliary input and support of the Impaired Physician Program has been noted as a necessary element of its present and future success and growth. Addiction to alcohol or any other drug is a family illness. Treatment must involve the family, as must recovery and follow-up care.

As the FMA Auxiliary member of the Impaired Physician Committee, I continue to be deeply involved in my assignment. I ask Auxiliaries to join me in my involvement and to encourage their spouses to do the same.

In answer to the question, "How could you do that?" — let us all respond — we can do that because we are informed. We can do that because we care about one another.

Physicians' Confidential Assistance



Call (305) 667-8717

... if you, or a physician you
know,
have an alcohol or other
drug-
related problem.

Committee on Impaired Physicians

An Auxiliary Looking In From Within

Mrs. Danilo P. (Hedy) Aquino

There are people, organizations, places and moments whose conjunction strikes off an ecstatic aroma both gratifying and memorable. To me, it produced an aura of self-fulfillment and started an enjoyable feeling of establishing my separate identity from my husband's role in the medical field and ultimately gave me an opportunity to get involved in community affairs.

Back in the early 1970's, while still living in the cozy neighborhood of Valley Hill Drive in Lakeland, I became impressed with the friendliness and congeniality of our neighbors, many of whom were getting involved in community efforts. It was during those frequent coffee sessions that discussion of their involvement and contribution to society gave me an insight and a wider horizon how a homemaker like me can do something for the common good during my spare time. I had some limited experience in civic voluntary work during my college days in the Philippines, and this background gave me a feeling that I could be of some service in civic activities. I felt that being an active member of a group like the Polk County Medical Association Auxiliary would not in any way disrupt my primary role as a homemaker, helpmate and stand-in for my husband whenever needed.

So, as a doctor's wife, I became a member of the PCMA-A without any reservation or misgivings of what the future might hold for me. It was in those early years of my membership that I developed a greater urge to contribute my bit for the organization and its growth and stupendous successes. PCMA-A is a dependable contributor to the public good and has won the respect of the people in the county.

In 1977, we moved to Lake Wales, where my husband's medical clinic is located. In this smaller locality it was easier to meet people and to win their friendship and respect. I was appointed chairperson of several standing committees of the PCMA-A chapter in Lake Wales promoting projects for the MAP (Medical Assistance Program), SKIP (Scholarship for Kids of International Phy-

sicians), and also the Interplast which provides plastic surgery for children to correct major birth defects. We held numerous craft bazaars to raise funds for these projects and it was a very comforting thought to note that the whole membership of our chapter cooperated wholeheartedly in all undertakings. Special mention is in order for my co-chairperson Judy Casingal; the help and encouragement given by Mesdames Carol Shull, Purita Biglete, Teresa Toruno and Carla Garcia, and others for their tireless efforts to help insure the success of our projects. Also, it was noteworthy to mention that a loyal friend and compatriot, Mrs. Biglete was always on hand to provide us with nourishing and delectable snacks.

I became the Treasurer of the PCMA-A in October 1979. The appointment was rather sudden and I felt that the position was rather herculean for me, but the persistent urgings of friends like Mrs. Dean Shull, former President of the PCMA-A, gave me the confidence to accept. Another factor that encouraged me to accept was the presence of my own mother at home; she could be depended upon to run the household as well as to take care of my children while I went to meetings and social benefits for the organization.

Of course, there were some disruptions, especially when I gave birth to my third daughter on June 2, 1980, but PCMA-A came to my rescue by providing an assistant treasurer. But things cannot last forever and after a year's term, I was appointed by our present PCMA-A President, Isabella Laude, to be the Chairperson for International Health Activities (IHA).

The PCMA-A Lake Wales area decided to hold a Dinner-Auction on October 16, 1981 at the Lake Wales Woman's Club. This was to raise funds for International Health Activities (IHA) and for scholarships (AMA-ERF). It was in my capacity as chairperson of the International Health Committee that I exerted all efforts to make the undertaking a complete success. Luckily, business firms, professionals, other prominent citizens and fellow auxiliaries were very cooperative and the affair was considered a success.

During the hectic preparation of the Dinner-Auction I was hurrying to attend a meeting when I forgot to notice that the prized fishing rods and reels of my husband (an amateur fisherman) were on the roof of my station

The Author

MRS. DANILO P. (HEDY) AQUINO

Mrs. Aquino resides in Lake Wales and is a member of the Polk County Medical Association Auxiliary.

wagon. When I arrived home from the meeting, my husband inquired as to the whereabouts of his fishing equipment. It was only then that I realized they were stolen where I parked my car. I was crestfallen but then I comforted myself that on that particular day, I was able to collect numerous valuable articles and donations for the auction.

The Dinner-Auction was successful and we received

many commendations from interested citizens. This and other projects undertaken were quite tiring but I for one had the satisfaction of a job well done.

My connection with the PCMA-A gives me a pleasant and enjoyable feeling that a mother and a homemaker — if she wants to — can contribute her bit for the common good and make the community a better place to live in.

Auxiliary Involvement in FLAMPAC In 1981 - 1982

Mrs. B. David (Edie) Epstein

The definition of auxiliary is: giving help or support, assisting and aiding a group, a unit subsidiary to the main body. I encourage you to take advantage of the FMA Auxiliary, an extraordinary resource consisting of approximately 5,000 members. Can you envision the enormous political potential when auxiliarians and physicians combine their efforts for common goals?

Auxiliarians have the time, interest, dedication and desire. We will acquire the necessary skills and expertise to participate as equal partners in the selection and support of candidates who are friendly to medicine, who adhere to the free enterprise system, and who are honest, fair and willing to listen. There are two avenues for mobilizing these resources — political education activities under the sponsorship of the Auxiliary and political action programs which are carried out by individual auxiliarians as part of the Florida Medical Political Action Committee's (FLAMPAC) endeavors.

The Auxiliary FLAMPAC Committee consists of a state chairman; seven district representatives who serve on the two FLAMPAC committees, membership and political education; and 40 local chairmen, one in each organized Auxiliary and branch. In addition, a past Auxiliary state president is currently serving on the AMA PAC Board of Directors. This network acts as an informational and educational resource. These auxiliarians combined with county medical society PACs and FLAMPAC support structures can be the core of Florida medicine's political activist efforts.

The work load for this committee is varied and vital. Members will assist in the identification, evaluation and selection of candidates, separating the turkeys from the eagles. They will scrutinize their platforms, voting records and their perception of the medical profession.

The Author

MRS. B. DAVID (EDIE) EPSTEIN

Mrs. Epstein, a Past President of the Florida Medical Association Auxiliary, lives on Key Biscayne. Currently, she is FMA Auxiliary FLAMPAC Chairman and a Board member of FLAMPAC.

They will attend public forums where legislative delegations meet and encourage articulate, knowledgeable representatives to speak to pertinent issues. They will invite them, their spouses and aides to our meetings and social activities. This develops a closer bond between the legislator and the medical community. We want to know them; we want them to know us. When possible, we will meet with our legislators prior to and during sessions. We will apprise them of our views on specific pieces of legislation and express our appreciation for their efforts. As their jobs become more involved, they will depend more on FLAMPAC, not only for financial contributions, but for our expertise and grass roots support.

This brings me to our major thrust for 1982 which will be spearheaded by individual auxiliarians — the identification and recruitment of political activists state-wide. Due to redistricting and reapportioning, every seat in the House and probably every seat in the Senate will be up for election. We must join forces and build a political base for the immense task of selection and election of our candidates. Since we are dealing with a volunteer effort,



State Rep. Helen Gordon Davis; and Mrs. Leslie (Phyllis) Chisolm Jr., at Hillsborough County Legislative Forum.

the auxilian is a natural, being visable, astute, group-oriented and accustomed to working within a voluntary organization. Using the combined core of auxilians and county medical society PAC members, we can build our projected number of 500 political activists. These activists will become involved in the campaigns of the candidates of their choice.

Campaign work is an exciting learning experience and I invite you to join us. Politics is not a dirty word, but rather a worthwhile endeavor that is deserving of our enthusiastic support.

We will be participating in activist training sessions on two levels. The first will be a series of regional workshops held in March and April. These will be intense, in-depth sessions conducted by American Medical Political Action Committee (AMPAC) staff emphasizing the training of physicians and spouses who will be leaders at the local level in the 1982 elections. The second level will be a series of local workshops held in April and May. These will be aimed at developing enthusiasm and giving basic training in various volunteer tasks such as phone banks, precinct canvassing, hosting coffees, etc., to the broad base of campaign workers. These will be conducted by FLAMPAC staff, physicians and Auxiliary leaders. We will be planning and implementing voter registration projects, deputizing members, distributing absentee ballots and assisting in aggressive "Get Out the Vote" campaigns. Further, we will keep our members and spouses informed about the political process and their responsibility, as individual citizens, for involvement in it.

These programs of the Auxiliary are encouraged and supported by the Florida Medical Association. They are carried out within the parameters of the relationship between FLAMPAC and the Florida Medical Association Auxiliary. Let us combine our efforts and fly with the eagles. Thank you.



Dr. Sylvia Carra, FLAMPAC Chairman, Hillsborough County; Mrs. Luis (Ana) Crespo; and Sen. Pat Frank.



In upper picture, Arlene Flitoff, Mary Todd and Jane Eberly of Broward County work in a voter registration drive. In lower picture, Mr. Eugene Johnson, Manager of the FMA Miami office, addresses the Spring Workshop while Ann Swing looks on.



A Night to Remember

Mrs. William H. (Jackie) Harrison

I was alone in my rambling three story house. Serenity enfolded the night. The Northeaster had churned up eight-foot waves that pounded the sand dunes to break the silence. The silver cast of the moon beamed a subtle haze through my bedroom window. "What a lovely night for relaxing," I thought.

Unexpectedly a gust of wind blew open the French doors leading to the balcony. As I sprang to close them, two buoyant forms emerged from the ocean. One was singing and the other was dancing. The lyrics from "The Sound of Music" ethereally ascended and I was certain that one of the specters was Mary Ann Mathews. The other kept demanding, "Get Into The Act". I asked myself if this was my conscience chastising me for the many Auxiliary meetings I have missed during the past four years.

No sooner had I locked the doors than a pair of legs resembling Connie Moore's ran through the room. Another pair in hot pursuit exclaimed, "Legs Alert!"

My hand reached for the telephone but it froze as I remembered that my husband was on a call and all my friends were at an Auxiliary meeting.

I switched on the television set and the announcer declared, "... and now a Galaxy of Stars!" The featured performer was Ruth Coleman, who led a parade consisting of Gloria Nunn, Dot Foley, Alice MacDonald, Joan Selander, Betty Orr, Mae White, Jo Ann Stump and a host of strangers.

"I must be hallucinating," I thought. "A good book will restore reality."

At this attempt to abate my apprehension "The Sound of Music" rejoined. I had not been mistaken! Mary Ann Mathews and Anne Swing were actually in my room! "We have come to take you to an Auxiliary meeting," they said. "Many changes have taken place since you were last there."

The Author

MRS. WILLIAM H. (JACKIE) HARRISON

Mrs. Harrison, a former President of the Florida Medical Association Auxiliary, resides in Daytona Beach.

To this day I cannot perceive how I arrived but I found myself suddenly transplanted in the midst of a Broward County Auxiliary meeting. They were having a Silly Hat Contest. The door bell rang and a man wearing a silly hat walked in to present himself as a candidate. Anne began to pace back and forth carrying a sign which read, "Men In The Act." I knew that the AMA Auxiliary had changed the magazine, *Doctors Wives*, to *Facets* but this was too much! Anne began bragging, "Florida has the third largest membership in the United States and won the AMA Auxiliary membership award again!"

Before I could recover from the shock, I found myself at still another meeting. Introductions were taking place. No one sang the praises of her physician husband. They were expounding upon their own professions and activities. "Is this the new breed of doctors' wives?" I wondered.

A banging gavel preceded the proclamation by Edie Epstein, "Hear ye this! All past presidents will attend the Gavel Club."

I grabbed my gavel and attended the first club meeting of the past presidents of the Florida Medical Association Auxiliary, Inc. It was great fun to see my old friends. The entertainment consisted of a high school choral group comprised of students throughout Florida. I had difficulty understanding their theme song, "HOSA." I thought it was some kind of abbreviation of "Hosanna" but Mary Ann said that it stood for Health Occupations Student Association which had replaced the former Health Careers Clubs. No wonder Buddy Brokaw kept running through singing, "Yes, Sir, That's My Baby."

Betty Orr was stirring a gigantic pot. It was called, "Auxiliary Stew." She told me that the recipe would appear in the Auxiliary's new cookbook being published this year. The Auxiliary sold its copyright of the successful old second edition.

Diane Nail and Wanda McDermon seemed to blend into a single male figure — a handsome young blond. "I am the new Executive Director of the Florida Medical Association Auxiliary," he kept saying. "What a sneaky way to get members," I thought and then added, "but a clever one."

I pulled out my checkbook to buy Christmas gifts at the Fall Board meeting but there was no Bazaar for

the International Health project! Instead there was a silent auction. I stealthily slipped into a chair in one of the meeting rooms and was promptly yanked out of my seat to *participate!* No more lectures! Furthermore, the meeting was conducted by professionals.

It was difficult to digest all the programs, projects and changes. Of one thing I was certain. The Auxiliary was comprised of intelligent progressive women and this

had not changed. I was happy to see the current and timely format.

Back in my room, I joined Mary Ann in her "Sound of Music" and told Anne that I was planning to "Get Back Into The Act" to perform in Ruth's "Galaxy Of Stars."

The evening was gone as they drifted away. I heard my husband returning from his call. I said, "Honey, I think I will become active again in the auxiliary." He smiled.



MaryAnn Mathews, President, Florida Medical Association Auxiliary, 1973-74.



Ann Swing, President, Florida Medical Association Auxiliary, 1980-81.



Judy Strand of Broward County (left photo) and Jane Eberly of Broward County and Susan Marks of Palm Beach County (right photo) at "The Silent Auction".

Isobel Dvorsky and The Auxiliary Factor

Dennis L. Breo

She comes quickly to her point: "We are ready to be discovered."

The organization is the AMA Auxiliary, formerly the "ladies auxiliary," and its current president, Isobel Dvorsky (Harry S.) of San Leandro, Calif., says both the auxiliary's image and mission have changed.

"As the AMA and state and county medical societies realize the powerhouse potential of the auxiliary," Mrs. Dvorsky said, "I believe we will see more cooperation and involvement. We want to be equal partners with the physicians, doing and sharing programs and projects that can benefit from our talent and expertise. Medical societies can use their auxiliaries much more effectively.

"It's an idea that's long overdue."

The auxiliary, founded in 1922, clearly has come a long way.

Mrs. Dvorsky notes, "It was almost 60 years ago that a small group of physicians' wives got together to ask the AMA's permission to form an organization to 'extend the aims of the medical profession through the wives of doctors to the various women's organizations which look to the advancement in health and education, to assist in entertainment at all medical conventions, and to promote acquaintanceship among doctor's families so that closer fellowship may exist'."

From the modest beginning, the auxiliary has come to be an enormous driving force for constructive health programs, serving in different ways during different periods of American history — World War II, depression and inflation, Korea, physician and nurse shortages, Vietnam, shortages in allied health careers.

Quickly, Mrs. Dvorsky ticks off some accomplishments of today's auxiliary:

— "The pioneering of major community health programs, notably homemaker services, child abuse prevention, health careers recruitment, drug crisis centers, child safety. In 1980 alone, 6,667 community health programs were implemented by the auxiliary to benefit Americans young and old from all walks of life.

— "The maintaining of the auxiliary Project Bank, a magnificent tool that is unique in scope and value. Health projects started throughout the auxiliary's 1,000 counties are stored and shared. This means that a food program for the elderly that proves successful in Phoenix can also play in Peoria. The Project Bank currently has 900 outstanding programs, with new ones being added at the rate of 150 per year.

— "The promoting of our national Shape Up for Life campaign. In our first two years, we started programs to help people improve their nutrition and physical fitness. This year, we are expanding the campaign to include mental fitness, particularly the management of stress. We will have special emphasis on the joys and stresses of the medical marriage. Also, for years our national immunization awareness campaigns have helped guard people's health.

— "The expanding of our traditional efforts in areas of prime importance to the medical profession — raising funds through the AMA Education and Research Foundation to help medical students and medical schools; educating people about health care costs and the need for cost containment; representing a positive image of physicians in their communities; and lobbying for sound health legislation."

What it all adds up to, Mrs. Dvorsky believes, is that the active member has become medicine's newest "specialist." The auxiliary, she emphasizes, can benefit people's health and burnish the medical profession's image in ways that traditional medicine can never do. It is, in many ways, the doctor's best friend.

"The truth is," she said, "that the auxiliary is enormously powerful. As physicians' spouses, we have a very special ability to lead others in matters that relate to health because we have channels for getting information, finding out what needs to be done, and helping to motivate others to act. We have people power in our 81,000 members and in their families and friends whom they influence."

The auxiliary is not only alive and well, its president stresses, but is needed more than ever. "As government struggles to balance budgets by cutting services, including medical services," Mrs. Dvorsky said, "I see the auxiliary stepping in and helping fill those needs. The auxiliary should be the cornerstone of community health efforts.

The Author

DENNIS L. BREO

Mr. Breo is National Affairs Editor for *American Medical News*.



Isobel Dvorsky

As government funds for medical education diminish, I see the auxiliary helping fill that need by intensifying its fund-raising efforts."

Mrs. Dvorsky calls herself a "modern woman but one who is proud to carry on the old tradition of the volunteer. I work for a salary as a speech pathologist. I'm a city commissioner and serve on several boards. I'm a doctor's wife, a mother, and a grandmother. And I am a volunteer."

To the auxiliary president, the volunteer organizations are the very backbone of America. "Voluntarism is the very spirit of this nation," she says. "I think that recent reports of the decline in voluntarism may be a result of the tendency to use government services as a substitute for individual and collective action on a direct and personal scale. We allow problems to develop in fami-

lies, work, and neighborhoods — and when these problems reach crisis proportions, we hand them over to the state and federal governments and say, 'Here, you deal with it; it's too much for us.'

"This way of thinking must be reversed, and it must be reversed by working through the tens of thousands of voluntary associations — the churches, charitable organizations, private colleges and schools, research institutions, professional societies, women's groups, business and labor, and farmers' organizations. Herbert Hoover long ago stated the warning: 'If these voluntary activities were ever to be absorbed by government agencies, this civilization would be over. Something neither free nor noble would take its place'."

In medicine, Mrs. Dvorsky is determined that voluntarism and the auxiliary will prevail. Her priorities as president (she was inaugurated in June in Chicago at the auxiliary's annual meeting) are to increase the organization's membership and its programs. "We need new members," she says, "and we need to spread the word that we can do more."

As for membership, she says, "The auxiliary is the best bargain in town. For \$11 annual dues, a physician's spouse gains access to a democratic organization that sets policies and carries out programs that benefit every community in this country. Joining is never a matter of dues, but a matter of priority. We need to convince physicians' spouses that joining the auxiliary should be high on their list of priorities."

As for doing more, the auxiliary's new leader cites three programs. "We need to become more involved with the spouses of medical students and residents. These young people are our future. We need to do more to assure good health legislation. We must not only provide information on health bills, but also establish legislative alert systems, plan days at the legislature, hold workshops, and stir our members' interest. We need to help shore up the sagging American family. Families are the lifeblood of this nation and good health is a family affair."

The auxiliary, Mrs. Dvorsky concludes, "is a powerhouse, one that is uniquely qualified to be an equal partner with organized medicine in safeguarding the nation's health."

"And, remember, it is all made possible by volunteers."

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The Auxiliary Project Bank

Mrs. Michael J. (Candy) Murray

The depth and breadth of the 30 component auxiliaries in the Florida Medical Association Auxiliary and 900 sister auxiliaries across the United States is evident in the AMA Auxiliary Project Bank. Established in 1975 and housed at National Headquarters, it serves as a clearinghouse of information from which county and state auxiliaries can obtain materials on community service projects developed and implemented by other auxiliaries throughout the country. It is a communications mechanism through which national, state and county auxiliaries can share program information and ideas. These projects are as varied as the needs and interests of the communities they serve.

Currently the bank contains more than 850 projects in 14 main categories: aging, blood donor, children and youth, family life, fund raising, health careers, health education, health services, international health, mental health, physician/spouse activities, safety and screening. Each of these topics is subdivided to meet the diversity of projects which are submitted. For example, in the category of children and youth, there is information on child abuse, parents anonymous and day care centers. Under physician/spouse activities are programs ranging from welcoming new physicians to financial planning. In all, over 106 subdivisions are presently used.

Reporting to the Bank

Upon completion of a specific program, counties and state are encouraged to report the result to the project bank for possible inclusion. The size of the county or community serviced, the size of the Auxiliary promoting the function, the number of volunteers needed and a complete description of the project are required. On the national level the entries are reviewed, standardized, classified and then published annually in a cumulative catalog. An Auxiliary wishing to institute a particular kind of program or fill a specific need may check the catalog, request a program and adapt it to the local area. The

value of this service is clear from the average of 75 requests the AMA Auxiliary receives monthly. The Health Projects Committee reports this year that 486 counties emphasized the national "Shape Up for Life" campaign with a variety of programs on fitness, nutrition and stress. Other focuses show continuation of immunization awareness, health education K-12, infant/child restraints and organ donation.

Florida Contributions

The Florida auxiliaries have made worthwhile contributions to this sharing effort and I would like to note them to help further illustrate the Project Bank concept. Florida has done well in health education. Brevard County auxiliaries became CPR instructors, Volusia County established a comprehensive exhibit of the reproductive system and birth process, and Hillsborough County set up a medical room in the Tampa Junior Museum. Taking an innovative bent toward nutrition, Dade County presented a "Shape Up" puppet show in local malls stressing good food and exercise for children. During Living Bank Week, Volusia County carried out an intensive public awareness campaign on organ donations.

To round off these superb health education programs we find Dade County manning Tel-Med phones, Clay County establishing a monthly "For Your Information" newspaper column on medical subjects, and Brevard County presenting a Worry Clinic. In another specific area, Charlotte County held a telethon during Blood Donor Month to replenish hospital supplies. Good Emergency Mother Substitutes (GEMS) programs have been reported by Orange and Dade Counties in which they teach teens to care for children and infants and include instruction in accident prevention and emergency first aid.

Various screening projects have had the help of county auxiliaries. Broward aided in hearing screening in private schools, sponsored a portable classroom "Reading Center" for functional learning disabilities and screened 6th through 10th graders in private schools for scoliosis. Brevard auxiliaries also assisted with scoliosis screening of 7th through 9th grade students. These and other activities illustrate the caliber found in the Project Bank and definitely reflect the unique character and capabilities of the medical society auxiliaries across the state.

The Author

MRS. MICHAEL J. (CANDY) MURRAY

Mrs. Murray, a Fort Myers resident, is Health Projects Chairman for the Florida Medical Association Auxiliary.

Package Programs

In addition to the Project Bank, physicians and auxiliaries may benefit from one of AMA/A's Package Programs. Available at no cost for one copy, these packets include essential information and ideas for community programs, extensive bibliographies of pamphlets, films, teaching aids and resource organizations. Current programs deal with alcohol, drugs of abuse, focus on kids, food for fitness, blood donor programs, health education, health manpower, mental health, services to the

aging, smoking, STDs (sexually transmitted diseases), shape up for life and impaired physician. All material is well organized by authorities to best assist in the education of your community in health areas.

The good public relations fostered by these programs is a built-in benefit for the medical profession. Use of the Project Bank and other resources need not be confined to auxiliaries, but can be a valuable tool of medical societies as well. It should be the function of the county auxiliaries to make the societies aware of the numerous sources of material available from the national auxiliary in health-related fields.

An Auxiliary Legacy

Mrs. F. Norman (Elizabeth) Vickers

A century ago, before the days of medical auxiliaries, the wife of a Pensacola physician demonstrated her capacity to see the drab and give it color; to observe the barren and infuse life into it; to experience discomfort and work to alleviate it. This woman, Martha L. Sternberg, set the stage for modern medical wives in northwest Florida.

In September 1872, Capt. George Miller Sternberg, Assistant Surgeon, U.S. Army, and his wife, Martha, came to Fort Barrancas in Florida where he assumed the duties of post surgeon.

Fort Barrancas was located on a 30-foot bluff, nine miles southwest of Pensacola. It had a commanding view of Pensacola Bay and the Gulf of Mexico. However, there were no living quarters within the vast brick structure. Housing for the military personnel and their families, as well as the post hospital, were located on a sandy, almost treeless plateau adjacent to the fort. The physician's house was a poorly designed and carelessly built dwelling. The yard was barren. Snakes were a common sight. Mosquitoes were a grand nuisance. The specter of yellow fever always hovered over the area during the long, hot summer months. Pensacola, the nearest town of any size, was accessible only by boat or a rough road through the woods. Fort Barrancas was a dismal place to be.

However, Mrs. Sternberg did not waste a lot of time dwelling on her misfortunes. She acknowledged them and then turned to her creativity for solutions.

Beautifying Surroundings

Perhaps the magnificence of Pensacola Bay and the Gulf of Mexico inspired the Sternbergs to see the potential for beautifying their immediate surroundings. They explored the woods and the edges of swamps for new varieties of grass and blooming plants. These transplanted specimens thrived in their yard which they enriched with fertile soil imported by cooperative schooner

captain. The building of a net-covered structure on the porch enabled them to enjoy the evening breezes and the colorful garden, despite the pesky mosquitoes.

Providing food for the table was another formidable task that Martha Sternberg encountered. Part of the solution entailed learning how to raise chickens and keeping a milch cow. Fresh fish were always available in the bay and the Sternbergs made it a recreational activity to row out to the ruins of Fort McRee and fish for their supper.

At times, loneliness and fear must have crept into Martha's life. Since the Sternberg's quarters were some distance from the other dwellings, her safety was a consideration when Dr. Sternberg was away from the post. In the doctor's absence, a servant was assigned to stay with Mrs. Sternberg and she later wrote that she always kept a loaded revolver at hand.

Post Civil War Pensacola provided little intellectual stimulation, so the Sternbergs fell back on their own resourcefulness. Their curiosity was stimulated by the local folklore about the ancient Indian mounds in the surrounding wilderness. The Sternbergs organized camping expeditions to search for these archeological sites and were successful in locating several. They carefully excavated the mounds and found many artifacts that contributed significantly to knowledge about the Indians who had inhabited this region. Dr. Sternberg wrote a report on this scholarly work and it was read at a meeting of the National Association for the Advancement of Science in 1879.

Yellow Fever Epidemic

In 1875, a severe yellow fever epidemic broke out at Fort Barrancas, and it forced Mrs. Sternberg to leave the post. She was reluctant to go since she had always remained at her husband's side in previous emergencies. However, she was given no choice. She had never had yellow fever, and it was too risky for her to stay. Accompanied by a military guard and a servant, she and a civilian guest left Fort Barrancas. Their wagon carried tents, camping equipment and a month's supply of provisions. They rode in search of a place to stay but no one would accept the refugees from the infected post. It was night before a poor, country family took pity on Mrs. Sternberg and her guest and allowed them to stay in their house.

The Author

MRS. F. NORMAN (ELIZABETH) VICKERS

Mrs. Vickers, author of several articles published in past issues of *The Journal* and a former nurse-educator, resides in Pensacola.

By morning, this good samaritan act had attracted the attention of the quarantine officers from Pensacola and guards were posted around the property. No one was allowed on or off the premises until the emergency was over a month later. Mrs. Sternberg's imprisonment became torturous when she received a message that her husband was gravely ill with yellow fever. Quarantine regulations prevented her from going to him. Three weeks elapsed before she received further information about his condition.

Dr. Sternberg eventually recovered, and he and Mrs. Sternberg were reunited.* Their experiences at Fort Barrancas had been a test of their inner strength, their capacity to survive, their concern for others in their lives and, above all, their willingness to search for beauty and meaning in the place where they happened to be.

In this Special Auxiliary Issue of *The Journal of the Florida Medical Association* it seems appropriate to pause and reflect on the legacy that Martha Sternberg left to the Auxiliary members. Mrs. Sternberg lived in a time when there were no medical auxiliaries. Women's roles were rigidly structured; their freedom was narrowly defined. However, despite this framework, Martha responded creatively to her experiences as a physician's wife and thus realized much personal growth. She enriched her life and the lives of those around her. She unintentionally set some high standards.

Women's roles have changed dramatically since Martha Sternberg's day. Their life's experiences have broadened; their freedoms have achieved new limits. Medical Auxiliaries have emerged. Nevertheless, the timeless legacy of Mrs. Sternberg is still meaningful to medical spouses of today. Her spirit urges us to see the drab, observe the barren, acknowledge the discomfort and to respond creatively.

The story of Mrs. Sternberg parallels the story of the medical Auxiliary. Each is about a pathway that leads to creative response.

*Dr. Sternberg later achieved national recognition for his work in bacteriology, and he subsequently served as surgeon general of the U.S. Army, and as President of the American Medical Association.

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Shared Roles

Mrs. N. Harry (Liz) Carpenter

As the role of American womanhood has changed in modern times, so has that of medical auxiliaries.

Once preoccupied with teas, luncheons and other social activities, today's medical auxiliaries have inventoried and energized their multiple and varied talents, bringing them to bear on the needs and problems of their communities.

As a result, from national through the smallest county Auxiliary, members today have changed from a minor to a major role in their communities. Highly-qualified auxiliaries now spearhead community projects, rather than be bystanders. This capable leadership has been a great windfall to medicine, as well as to communities from coast to coast. Each year adds new dimensions to the growing role of auxiliaries, and old ideas and role models of the past are being swept away forever. Medical spouses have always been people of intelligence. Today's auxiliary is not only intelligent, but also educated, capable, and most important, fast becoming experienced in leadership and success.

So just what are auxiliaries doing now? Probably the biggest single change in Auxiliary work has been on the political aspect of community life. Approximately two years ago, FLAMPAC's staff turned, in desperation, to county auxiliaries and asked for help in alerting doctors to "Recovery of Costs" legislation. Auxiliaries were asked to generate from physicians letters and telegrams endorsing such legislation; the project was termed "LEGS ALERT." Auxiliary was a last ditch effort in this matter, for opponents of the legislation had stripped other professions from the bill until medicine stood alone. Further, the strong lobby of trial attorneys was opposed. Auxiliaries went to work all over Florida. They organized so well and on so broad a front, that they have been credited with bringing the legislation into being almost single-handedly. Auxiliaries stopped gaps and applied pressure on legislators, not once, but every time the bill was in danger. Organized medicine was amazed, the Auxiliary delighted.

The Author

MRS. N. HARRY (LIZ) CARPENTER

Mrs. Carpenter lives in Fort Lauderdale and is Recording Secretary of the Florida Medical Association Auxiliary.

The success of this large and far-reaching task finally brought auxiliaries face-to-face with their own power and abilities. Physicians know a good thing when they see it, and seeing their spouses orchestrating a major victory earned the auxiliary a place alongside the physician in the legislative process.

Long before the public victory, winds of change and progress were blowing within Auxiliary. Auxiliaries and physicians had started jointly-sponsored projects within their communities and were working together as never before. In order to have a statewide glimpse of the extent of these programs, a number of counties around the state responded to a questionnaire concerning joint (auxiliary and medical association) activities. Twenty-two such combined programs, now in use in at least one county in Florida, were reported and are summarized as follows.

The most common areas of cooperation were joint meetings, FLAMPAC activities, Legislation Committee work, FMF and AMA-ERF fund-raising, Doctors' Day celebrations and the use of physicians as speakers at Worry Clinics and Health Fairs. In many counties, both organizations contributed to scholarship programs.

Four counties (Manatee, Sarasota, Broward and Dade) combined their efforts with their medical associations on the Impaired Physician program.

Unique programs were:

- Blood Bank Drive for Doctors' Day (Sarasota)
- Physicals for Physicians (Broward)
- Physician Models at a Benefit Fashion Show (Capital)
- Joint Sponsorship of a Drug Abuse Program (Manatee)
- Free Physicals for Contestants in Special Olympics (Marion)
- B.S.E. (Breast Self-Examination) and Pap Smears for High School Students and Senior Citizens (Marion)
- Identification of Multi-lingual Physicians Who Can Aid Non-English-Speaking Patients (Broward)
- Free Physicals for School Athletics (Pinellas)
- An Essay Contest on "My Favorite Doctor" for 2nd Graders with T.V. Coverage (Dade)
- Physician-Attorney Sports Contests for Doctors' Day (Volusia)

A new phenomenon, occurring since 1978, is the inclusion of Auxiliary members on medical society committees. In Broward County, the Auxiliary president is

invited to BCMA meetings and an auxilian is on the county medical journal staff. In Volusia, Auxiliary members are regular contributors to the society publication. In Seminole, auxiliarians are invited to the scientific sessions as well as the dinner and parties. In Dade, in addition to the already mentioned committees, auxiliarians serve jointly with the physicians on Public Relations, Program, School Health Advisory and the Executive Committees.

At the State level, there are five members of Auxiliary working closely with the FMA. They serve on the Committees on Legislation and Impaired Physician, the FLAMPAC Board of Directors and as Consulting Editor and Guest Editor for this Special Auxiliary Issue of *The Journal of the Florida Medical Association*. "Shared roles" is an idea whose time is now, for it is only reasonable that the education, talent and experience to be found in county auxiliarians be put to work in some useful fashion.

Some Auxiliary units still have some way to go before fitting completely the modern mold of service and involvement. My personal goal is to encourage the medi-

cal society to keep on using the Auxiliary as its strong right arm in support of its programs and projects.

In areas where we have not become this strong right arm, we can earn confidence by setting good examples and performing good work. In every area there are enthusiastic auxiliarians who seek new and more important roles.

Each Auxiliary unit should bear in mind that our state theme this year is "A Journey Through the Galaxy" and check to make sure its members are truly reaching for the stars.

Acknowledgements

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Carol Frei, Jane Eberly and Liz Carpenter of Broward County at Fall Conference.



Gayla Case and Ann McKee of Polk County with their award-winning Doctors' Day book.



Doctors' Day in Polk County was celebrated by Dr. Felix Cruz, Dr. Nicholas Alfonso, Dr. William Toruno and Teresa Toruno.



Dr. and Mrs. Harold Seder attending a joint meeting of the Pinellas County Medical Society and its Auxiliary. Joyce Seder is President of the South Branch Auxiliary.



Dr. and Mrs. Gary Keats attending the joint meeting of the Pinellas County Medical Society and Auxiliary. Judy Keats is President of the Central Branch Auxiliary.



Notables attending the Pinellas County joint meeting included Dr. and Mrs. Morris LeVine. Dr. LeVine was the outgoing President of the medical society; Marilyn LeVine is the Auxiliary President.



Committed to greater involvement by physicians and their spouses to community service are FMA President Sanford A. Mullen, M.D.; FMA-A President Ruth Coleman and FMA-A President-Elect Gloria Nunn.



The lone gentleman in this picture is FMA-A Executive Director Russ Berge at the 1981 House of Delegates meeting.

New Roots

Mrs. George (Claire) Trodella

Shortly after moving to Ft. Lauderdale (from the Boston area) I was discussing the difficulties of finding my way into the mainstream of community life with a neighbor who was a recent transplant from the Midwest.

With great enthusiasm we expounded on all the positive aspects of Florida living; the year-round golf, the proximity to the ocean, the magnificent sunrises and sunsets, etc.

Then we fell silent for what seemed like a very long time. We each were thinking of the things we had left behind; family members, valued friends, a standing in the community, a sense of roots and of belonging.

What were we doing in this land of sunshine and flowers, and of displaced people?

Finally she spoke again. Pensively and with great sincerity, she said, "I envy you your medical connection.

"You can join a medical auxiliary and 'Voila!' you have instant rapport with a whole group of women," she explained.

How wise and right she was; I had never thought of it in those terms.

Back "home" in Boston I had joined the local medical Auxiliary because my husband was chief of Obstetrics and Gynecology (for 23 years) and as a good and dutiful wife I was expected to actively support the hospital.

It didn't occur to me as I went up through the chairs and ultimately served a three-year term as President that I was reaping the reward of building treasured friendships and growing in the ability to initiate projects and see them to a successful conclusion.

During those years as I plodded through the endless rounds of fund-raising and consciousness-raising, it never occurred to me that I needed the Auxiliary; I figured the Auxiliary needed me!

But the truth of my neighbor's observation struck home.

A medical wife is a part of a sisterhood with very special rites of passage. We have a bond born of mutual experiences dictated by the very nature of our husband's work.

We know the frustrations of raising children with an all-too-often absent father figure to fix a bicycle, coach the Little League baseball team, or help decorate the tree on Christmas Eve.

We have accepted with resignation "being left at the Ball" more times than we care to remember. A hastily sputtered "if I'm not back by 11:30, have the Moores take you home," marks the end of an evening that we've spent hours primping for and anticipating.

We've bristled over blighted holidays, pouted over postponed vacations, and wondered in exasperation why we ever chose this man with his all-demanding profession to be the father of our children and the light of our lives.

For better or for worse, a physician's wife is inextricably concerned with the medical profession. It colors her life . . . sometimes blue.

When the media attacks the medical profession and maligns physicians as a group because of the shortcomings of a few, we see red. How dare they chastise the whole profession? Why don't they give equal time to the well-trained, dedicated, hard-working men and women we know and love who have made the pursuit of medicine the cornerstone of their lives?

We acknowledge with sadness the problem of the impaired physician. We note, with consolation, that finally the problem is being faced with candor and will no longer be swept under the rug. We know with certainty that we are passionately concerned with the image of the most honorable of all professions. Along with marriage vows, we took another vow. We promised to protect that image in subtle and substantial ways. Join the Auxiliary? Become actively involved? By all means. As soon as the last cup is hung, the diplomas are in place, the "Welcome to Florida" flowers have wilted, we are ready to establish new roots.

The Author

MRS. GEORGE (CLAIRE) TRODELLA

Mrs. Trodella is a member of the Broward County Medical Association Auxiliary.

Rx: For a Healthy Medical Marriage

Judith B. Marquit

Does the medical profession place so many demands on you as an individual that the relationship with your spouse is affected? Are you both satisfied with the quality of your relationship?

Recently, generous attention has been focused on these provocative issues. The media has been examining the medical marriage. The mystique surrounding the physician has always caught the imagination of the general public. That aura surrounds the physician's spouse as well. The medical marriage has been probed, attacked, romanticized and defended through the scientific and popular literature, as well as on network talk shows and in soap operas.

The result of such exposure is that the public now knows what we have been aware of for some time — the prognosis is good for the future of many doctors' marriages. However, the experience may not always be a healthy one.

Despite the dichotomy inherent in medicine and marriage, the vast majority of physicians' relationships do not end in divorce. In fact, the rate among such marriages is dramatically low in contrast with other comparable professional groups.

However, while they appear stable, some relationships may fall short of individual expectations as sources of satisfaction and pleasure. Frequently the lack of mutual gratification for one or both partners may result in the emergence of hidden personal conflicts, and a potential deterioration in the marital relationship.

Although many medical marriages are rewarding, satisfying and robust, others may be in poor health.

The Devitalized Marriage

Researchers suggest that some doctors are willing to settle for less than a perfect marriage. The devotion they have to their profession almost always takes precedence over the condition of their domestic lives. Similarly,

their spouses may offset the anger, frustration, and emotional emptiness they experience by looking towards the social and economic advantages they enjoy. Some are defensive regarding the problems that affect their marital relationship. Others may cloak their personal conflicts behind the protective veils of prestige, power and materialistic accoutrements.¹

What often emerges in such a relationship is two people simply coexisting together. John Cuber, who began professional marriage counseling in the United States, has described this phenomenon as "The Devitalized Marriage." Such a union exists for the purposes of maintaining the home and raising a family. The couple no longer has anything significant to say to one another.²

Although this description may reflect a mere phase in the marital cycle, it can also be indicative of a permanent pattern within the relationship. Could this pattern be characteristic of many physicians' marriages?

This "devitalization process" has the potential of beginning during the early years of medical training. It is not long before the young couple realizes that the medical profession is intruding on their relationship. The physician in training is plagued by the pressures of the medical school and hospital experience. It fosters inaccessibility and chronic fatigue. The luxury of taking time to explore and experience one another is no longer as available as it was during courtship.

The young doctor soon becomes preoccupied with the exciting and seductive world of medicine. The spouse, and later the children, may be relinquished to a secondary position. The communication that once cemented the relationship together is often replaced by disappointment, frustration and bitterness. Some marriages dissolve. However, the majority manage to sustain themselves through this difficult period in favor of a future that promises greater satisfaction and pleasure.

Nevertheless, patterns established during the training experience may endure throughout the years of the medical marriage.

Joseph Trainer shed light on the special hazards of medical marriages by identifying their common difficulties. The problems inherent in such relationships greatly resemble those early marital patterns established during the long years of medical training.³

The Author

JUDITH B. MARQUIT

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Such difficulties appear to stem from the dified aura surrounding the physician, as well as the psychological dynamics of both partners. In addition, the emotional and physical demands of the medical profession have a tremendous influence on every member of the nuclear medical family. Too often its impact may scar the marital relationship and "devitalize it."

Recommendations for a Healthier Medical Marriage

You Are Not Unique: If one or both partners are unhappy in the medical marriage; if frustration, anger, dissatisfaction as well as emotional and physical fatigue plague the relationship; be assured — you are not alone. Understanding that common problems do exist among physicians' marriages will help to place your own difficulties in their proper perspective.

Assess Your Priorities: Individual emotional problems and marital conflicts might be prevented by establishing a hierarchy of needs. Each partner should assess his priorities and create an inventory of personal needs in the order in which they are most important and meaningful to him.

Share individual needs with your spouse and realistically assess one another's ability to meet them. Combine both inventories to form a list of priorities as a couple and build it around the cultivation of your personal relationship. This process serves to open the doors of communication between husband and wife. Creating a hierarchy of needs promotes the formation of a more optimal lifestyle as a couple, as well as for the individual.

Communicate in Different Ways: A relationship thrives on communication. Set aside an hour (or even half an hour) for the two of you — alone. Communicate with each other and about one another. Take a walk, eat a snack together, participate in a mutual hobby, touch each other (remember, communication extends beyond the verbal stage as well). However, *do not* spend these special moments solving problems concerning the children, or how to deal with the leaky roof. Your time together as husband and wife is yours alone. Covet that time and be selfish about it.

Enjoy a Retreat: Vacations work wonders as preventative methods in combating emotional and physical fatigue in both spouses. In addition, they give husband and wife (as well as parents and children) the opportunity to enter each other's "life space." Time away from the daily responsibilities inherent in the medical profession reduces the barriers that often alienate partners from one another. Such a retreat may include an extended vacation, as well as a day in the park . . . any time spent away from daily routine.

Allow One Another to Grow: Maintain an interest in helping one another grow emotionally and intellectually. The physician is always immersed in a stimulating cognitive environment. Nevertheless, this stimulation is often narrowly focused on medicine. By striving for depth and breadth in experiential and educational pursuits the spouse can enhance that marital relationship. Allowing potential growth to take place in one another, and appreciating each partner's contribution, prevents atrophy within the medical marriage.

Mental Health Care: Seek professional help when you need it. Keep in mind that your marital conflicts are not unique. All of us have experienced them in different ways, and in varying degrees of intensity during the course of our medical marriages.

Our common problems are not readily shared because doctors and their spouses are often hesitant in addressing such issues — even among themselves.

The stigma associated with individual and marital therapy still remains pervasive throughout most medical communities. It is to their great misfortune that doctors and their spouses are reluctant to seek sophisticated mental health care. If you are willing to participate in a therapeutic experience and your spouse is not, do so. Allow yourself the opportunity to achieve more quality in your life — you will enjoy the experience.

Alternative Support Systems

A final recommendation towards healthier medical marriages is the potential organization of support groups formed within the auxiliary branches of the FMA. Small groups of physicians and their spouses would meet together as couples, or as groups of spouses, in a supportive atmosphere. During on-going sessions members of the medical community would have the opportunity to communicate with each other, listen, observe, and exchange ideas. An open dialogue surrounding the common problems, as well as the pleasures, of medical marriages might assist participants in dealing with personal, marital, and family dynamics.

The medical marriage creates a unique relationship between partners. Despite the sacrifices involved, it can be a rewarding, mutually gratifying experience. If each member is willing to work at fulfilling its real potential, such a marriage can be one that is special, and one that's worth holding on to.

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Gifts to Share: Sunshine and Storms Laughter and Tears

The Auxiliary as Part of My Lifestyle

Mrs. Walter (Isabella) Laude

It began May 11, 1957. The day started with rain drops, turned to snow flurries, and ended with a rainbow. By mid-afternoon the clouds began to roll away revealing bright sunshine and a dazzling rainbow. I witnessed this revelation as the precursor of a glowing future, for was I not now about to enter into the romantic, care-free lifestyle of the doctor's wife? What lazy days of fun lay ahead as I envisioned an ever-loving husband; respectful, grateful patients; considerate, thoughtful nurses; congenial, helpful colleagues; and, of course, those much-admired medical wives!

We packed the 1954 Chevrolet so full with wedding gifts for our beginning household that we couldn't see out the back. We were so loaded down that even the cans and the "Just Married" sign were crushed to the ground. After further delay and repacking, we headed for the sunny South. Although I loved the teeming, metropolitan area of Cleveland, Ohio, the halls of learning at Case Western Reserve University, and the bustling turmoil of the Cleveland Clinic Hospital, I felt no regret upon leaving the stormy clouds and windy shores of Lake Erie. The tears flowed freely at the moment of farewell with family and friends, but soon the beckoning drama of a new life brought on the sunshine and laughter. The sun shone all the way to Virginia.

It was during the Miami Beach honeymoon that the bride encountered more tears behind the sunshine, for this lily white Pennsylvania native, who had never before been south of the Mason-Dixon line, had her first exposure to the penetrating rays of the Florida sunshine. The result was a very painful, highly uncomfortable complication. The new husband now became his new wife's doctor. Treating an agonizing second degree sunburn is no

fun at anytime, but on a honeymoon? How could it have happened? Nevertheless, wasn't I lucky? I had my very own doctor to take care of me, and oh how I enjoyed the solicitous attention. Another harbinger of things to come? Alas! It was probably the first and last time that I was to be the sole concern of my doctor. Such was the beginning of my survival as a doctor's wife.

Big change number one occurred when the reality of private practice in anesthesia in a just-opened community hospital began for the modern doctor with the young wife. It was an exciting novel experience for him with unknown relationships to cultivate, up-to-date patterns of practice to develop, and a fashionable way of life to create. But, what about me? Where was the glamorous life I had conceived as a doctor's wife? Let me tell you what happened.

It was a Saturday special, the social event of the season with a wedding reception at the prestige place of Richmond, the Commonwealth Club. How I looked forward to meeting the people of my recently discovered city. Since there was ample time before my husband was due home, I leisurely bathed and dressed in my stunning, original outfit, complete with hat and gloves as befit a Richmond matron of the '50's, and eagerly awaited my charming cavalier. I waited and waited; the minutes became an hour, then two hours, and as the hands of the clock moved on later and later, I realized that this was not to be my grand appearance in Richmond society. Yes, you guessed it. My anesthesiologist never did arrive in time to take in the filet mignon dinner and kiss the bride at the Club. I've never forgotten that evening for I learned a valuable lesson.

The following day I complained long and bitterly to friend husband, to a sympathetic doctor's wife, and to anyone who would listen. It was on this occasion that "Marge" said, "Isabella, don't ever feel that you are alone. If your Walter does not show up on time, wait a little, but not a lot. Call us. We'll pick you up and see that you get back home again. "That's the way it is with doctors and

The Author

MRS. WALTER (ISABELLA) LAUDE

Mrs. Laude, President of the Polk County Medical Association Auxiliary, is a resident of Babson Park, Fla.

their families; we're all in the same family of friends. We know and we understand."

And, that's just the way it was. If I could share these thoughts and say the same to any new doctor's spouse it well might be a marriage-saver as well as a life-saver. We are in this life together and no one understands you, the doctor's spouse better than another doctor's spouse.

Big decision number one: Always be the proper wife, but never forget your own separate identity.

The next step was *big change number two*. "You do not need a job," said my chauvinistic husband of the '50's. "You do not have to work." One day he conceded, and I was off to get a job. This was no problem for I had an extensive background; however the Richmond of the '50's was awkwardly far behind the progressive medical centers I had known at University Hospitals and the Cleveland Clinic. I soon found myself as one of only a handful of nurses having a Bachelor of Science in Nursing. The pay scale was low. I did eventually elect to become a nursing supervisor, temporarily, and managed to write a few procedure manuals before reverting to volunteer work where the Red Cross and the Auxiliary took precedence in my life, which was *big decision number two*.

Along came *big change number three*. "Yes, you are pregnant," said the obstetrician. What did I know about babies? I had nine months to learn, or so I thought. Unfortunately, we lost this first conception. Eventually, however, we acquired five children, four of them in four years and I spent 15 years teaching Red Cross classes for expectant parents. Using the pamphlet I had written, we changed class format from "Mother and Baby Care" to "Parent Education" and started the first class with fathers at Richmond Memorial Hospital. Preparation for Parenthood became *big decision number three*.

With *big change number four*, Auxiliary assumed a more active role in our lives which has continued to this day. An understanding doctor's wife, Edith, invited me along to help in sponsoring a high school "Future Nurses' Club". I'm pleasantly amused when I recall how the young and eager students of the "Future Nurses' Clubs" listened carefully to our advice, dressed up to go on hospital tours, poured tea at meetings, and diligently prepared for the devoted career of a nurse. My whole lifestyle changed from spectator at Auxiliary functions to active participant in Auxiliary activities. Before this happened, I had fallen into the routine of the First Friday Luncheons where everything was beautifully planned and executed by someone else. My learning period was not over, but my casual observation was at an end. Henceforth, I became part of the show and gave up my seat in the audience. I evolved into an experienced, dedicated and satisfied volunteer in community service in an organization committed to cultivating fellowship and mutual under-

standing among medical families and assisting in programs for improving the health and quality of life for all. That was *big decision number four*.

Auxiliary enhanced my time introducing me to a whole new world of treasured friendships, priority issues, caring, and sharing. From Auxiliary meetings and workshops I gained insight into the legislative process and the workings of our government. Auxiliary service and contacts led me into the political arena with an extremely busy, varied, and interesting existence such as I had never known before. I served on a number of major committees with various political appointees and elected officials.

Big change number five conveyed me into state level Auxiliary functions. I was appointed by Governor Linwood Holton to the Virginia Committee for the 1971 White House Conference on Aging. I was the youngest member of the Committee, but not the quietest. Mine was the sole objection to modifications proposed for the changes in the Medicare program, without allowing for adequate representation from the providers of care. A presidential appointment to the WISH project, Women in Service to the Handicapped, representing the American Medical Association Auxiliary, was another means of serving my country and my Auxiliary.

Life at home was stimulating with positions on the Boards of several community agencies.

Ultimately there arrived the day when I spent the entire time hurrying from one meeting to another with still others to come that evening. I had completed my master's studies with a Master of Science in Rehabilitation Counseling. Life was full and there was much to do.

Then came *big decision number five*. Instead of always hearing the excuse, "Oh, I'm sorry I can't help, I work!", I decided to use that excuse myself. I went back to employment as a faculty member at Virginia Commonwealth University. Auxiliary retained a place on my calendar. My position as Doctors' Day Chairman focused on one of my favorite projects. This observance, marking a major milestone in medical history, brought deserved recognition to our doctors. The practice of awarding an engraved silver cup to the first baby born on Doctors' Day continues in the Richmond Auxiliary. The Governor's wife, the Mayor's wife, or other dignitaries partake in the televised ceremony. It was a delightful experience to be invited to the Governor's Mansion for a reception honoring past presidents of the Richmond Auxiliary hosted by the wife of the Governor of Virginia, Mrs. John Dalton. Prestige and pleasure are fringe benefits of Auxiliary friendships and service, not to mention the great satisfaction one feels at having accomplished something worthwhile.

Big change number six came just as I was contently settled into my life as a doctor's wife and my role in the

Richmond and Virginia Auxiliaries. My husband longed for the Florida sunshine and with the increasing population and expanding big city atmosphere of Richmond, we made *big decision number six* to seek the small town life of the Crown Jewel of the Ridge, Lake Wales, Florida. Whenever we were unable to locate suitable housing, I thought, or I hoped, Walter might change his mind, but that was not to be.

Shortly before Thanksgiving a call from Florida to Virginia confirmed that Walter had invested in a Florida future, and we were expected to make the move by Christmas. It was Christmas, 1972, when I received the biggest Christmas surprise I have ever seen. My husband of 15 years bought a place which was large enough for our family and even included space for his office. Having supervised a hugh city hospital, he reasoned, "you won't have any trouble whatsoever in managing my office and the hotel in which it is housed." The initial shock gave way to doubts, uncertainties and numerous questions; however as the storm and tears subsided, a ray of sunshine and laughter appeared. It was going to be great fun being owners of the Seminole Hotel, a Lake Wales landmark since 1925.

Our children thought it "neat" to live in the middle of town in their own hotel suite, but the Florida of 1972 was not the Florida of the 1957 Miami Beach honeymoon! There were five children and five different schools to which transportation had to be provided every day not to mention the astounding number of teachers, contacts, and extracurricular activities. Auxiliary came to the rescue as I located wonderful friends to help me reconcile my adjustment to the enormous change in my lifestyle. The one consistent, unchanged joy was the mode of life rejuvenated through Auxiliary. The small close-knit medical community of Lake Wales was but a fraction of the greater family of friends found throughout Polk County.

It was Doctors' Day, 1978, that brought me back, once again, as part of the show. Polk County had not yet had a Doctors' Day Observance. I tackled Lake Wales and by working with the Polk County President, Priscilla Gerber, and the Doctors' Day Committee in other sections of the county, Polk County had its first observance of Doctors' Day and brought home the Guy Smith Kirby trophy from Southern Medical. I was amazed to realize that many ideas of the greater Richmond environment had not yet arrived in this little metropolis with the big heart. The scholarship program was dormant in Lake Wales, but I found a Lake Wales High School student interested in a health career. Funds were lacking so Polk County Medical Auxiliary came to the rescue with subsequent scholarships being given to students pursuing

health careers. We resurrected interest in International Health projects and membership. As membership chairman, I have come to know and help recent arrivals reliving with each the anxious anticipation of life in a strange setting.

Having the responsibility of my own family and the operation of hotel and office, I was reluctant to take an Auxiliary office. Having already been a president I should have been content to rest on my laurels, but I again find myself as president of an Auxiliary. This time, however, it is quite different, and I am gaining a great appreciation of the complexities of an entirely fresh approach in the lifestyle so typical of this growing and developing area with many international dimensions. How interesting, educational, and broadening it is to discover not only South America, Central America, Europe, Asia, Africa, Canada, and Australia right here in Florida, and almost every state in the union. The cross section of medicine congregated here represents major medical centers from around the world. Traveling to Auxiliary meetings and workshops around the county and the State has enlarged my perspective immensely. I find myself thoroughly enjoying the attendance at meetings, sometimes with my husband; at other times with congenial Auxiliary companions. I meet fresh acquaintances, rekindle old friendships, and feel myself refreshed and revitalized from the challenging and stimulating associations. At last, I have come to the realization that after 25 years as an auxilian, there is no more fulfilling life than this one. Auxiliary is not just part of my lifestyle, it is my lifestyle! As I think ahead to the coming 25 years, I cherish even more the friendships I have made.

I am committed to a way of life that I cherish. There is always the happiness of caring, and being cared for by loyal, dear friends; a loving, considerate husband; precious, wonderful children and family; and my family of Auxiliary. If I could give you something to cherish it would be this above all . . . the hope that every doctor's spouse has the opportunity to choose Auxiliary as "part of my lifestyle" and that every doctor will encourage his or her spouse to do so. The choice is ours to make, for God has granted us much for which to be thankful. He has given us this land of plenty and our country of freedom. He has given us the storms and the tears, but he has also given us the laughter and the sunshine. May your tears become laughter and may your storm clouds pass away to reveal the sunshine and the rainbow of promise. What gift can last through the years: laughter and tears, sunshine and storms, and — Auxiliary! Auxiliary is my lifestyle. Make it yours!



Mrs. Walter Laude, President of the Polk County Auxiliary, with some of her officers: R. Ramsey, A. Lingenfeiter, M. Carey, and R. Gomez.

Challenge and Commitment

Mrs. Norman (Jane) Rosenthal

When I accepted the job of coordinating public relations for my county and the State Auxiliary, I had no idea the task would be so rewarding or the challenges so many. As a professional magazine writer, reporter and publicist, I had key contacts within the media, yet I discovered that obtaining coverage for Auxiliary events is only part of the job. The other half concerns our image.

We need to ask ourselves about the image we are projecting. Do we have a distinct image? Are we a social group that meets for monthly luncheons? Are we a service group? Are we a support group for the medical profession? How are we perceived by the community?

In Hillsborough County, we decided it was critical to define our role in order to grow and attract new members. We decided to create a brochure using photographs of involved auxiliaries which would project an image of caring and concern for the health of the entire community. The Hillsborough Medical Association supported our project because it dramatized the role of the Auxiliary and local physicians in furthering health education and community involvement.

Direction for the 80's

Through the medium of the brochure we were able to tell our story and diagram the direction our members would follow in the 80's. Following a brief history of the Auxiliary, which revealed that we had our beginnings in response to a request to gather surgical supplies, old journals and medicine samples for shipment overseas, the brochure goes on to describe community service programs in the fields of health education, health careers, support of HOSA (Health Occupations Students of America) through scholarships and awards, and support of legislation designed to maintain quality health care service for the entire community.

Public relations needs to emanate from a planned campaign. We cannot wait for the press to discover us.

With the invaluable support of Russ Berge, Executive Director of the FMAA, many counties are launching a public relations campaign to promote uniform donor cards for anatomical gifts. The FMAA was instrumental in having this legislation passed and counties are taking advantage of the opportunity to make the public aware of the plastic pouches and uniform donor cards provided with the issuance, or renewal, of a driver's license. In another case, news of an effective seat belt safety campaign in one county sparked interest in another area and is now being considered by many Auxiliary boards for Auxiliary implementation.

The Fall Conference

At our last Fall Conference, coordinated by President Mrs. Frank (Ruth) Coleman, the FMA Director of Communications, Samuel Flowers, shared his expertise in a stimulating "How To" session on publicity for Auxiliary leaders. If we are to grow in personal development, as well as in numbers, we need to take advantage of opportunities such as this to polish our skills and upgrade our talents.

Our publicity for the Tampa conference emphasized its educational value and the many outstanding conference participants drawn from our local community such as: Ruth Ann Fowler, columnist, well-known home economist, TV producer and lecturer; David Smith, Ph.D., professor of medical communications at the University of South Florida; and Jean Ware Smith, Deputy Director, Program on Aging, Hillsborough County Mental Health Center.

Working closely with the Legislative Committee of the medical association, auxiliaries have sponsored legislative forums and served as key contacts with legislators. This area is becoming increasingly important as Auxiliary members become involved in health issues and are frequently called upon to provide information and data about bills that relate to the practice of medicine.

Knowledge of Health Issues

The more informed and articulate we are on health issues, the more respected we are by physicians, county medical associations, legislators and the press, the better

The Author

MRS. NORMAN (JANE) ROSENTHAL

Mrs. Rosenthal, of Tampa, is the Public Relations Chairman of the Florida Medical Association Auxiliary and is a professional public relations consultant.

our image will be. The perception of us as a support organization is changing. Although we continue to promote friendly relations among physicians' spouses through membership coffees and annual Doctors' Day celebrations, we are coming to be perceived as community health care leaders with interests ranging from drug abuse programs to immunization.

Historically we have been awarding scholarships to deserving nursing students, sponsoring health careers clubs in the schools, and coordinating annual Health Careers Days for high school students and guidance counselors. Good publicity resulted from these opportunities to show that we cared about the community.

Concern for the well-being of children in the pediatric ward of a local hospital led one auxilian to design a storytelling hour. She enlisted the support of the hospital staff and administration as well as other auxilians to give their time to this project. The emphasis in the publicity for this project will be on how members of a local Aux-

iliary responded to a community need by demonstrating their concern for the smallest members of our community.

Challenges

With the increasing interest in health care today, many challenges to improve the level of knowledge continually confront us. Opportunities to do this in a highly visible manner are also ever increasing. Progressive medical communities have taken to the air waves and regularly have representatives on radio and T.V. Brochures, bulletins, newsletters, newspapers and journals can be duplicated quickly and easily. We now have at our disposal electronic means of communication that make it possible to pinpoint a serious health problem instantaneously. It is up to us to use these tools of communication intelligently and responsibly. Our image will depend on how effectively we communicate our responses on the important health issues of our time to the public.

Challenges for the Future

Mrs. Linus W. (Jane) Hewit

When we think about the Florida Medical Association Auxiliary's role in the years ahead, we must realize that it will be affected by the many changes taking place in the volunteer sector.

We know that no organization stands still. It either moves forward or slips backward, and the choice is ours to make. In the past 56 years we have become a powerful organization with a strong voice. Through the dedicated work and cooperation of officers, members and staff, we can look with pride at the significant accomplishments as evidence of our strength and success. As we look ahead and recognize that life is never static but constantly changing, we must adapt to new conditions and new challenges as they occur. We must continue to look for new and better ways to serve.

These new approaches must stimulate and motivate the membership. Volunteer efforts must be worthwhile, not only to those served, but stimulating to those serving. We must be more professional, for an ever-increasing number of auxiliaries are professional people. With the realization that most spouses of medical students, interns and residents are in the work force, and a large percentage have, or will establish careers of their own, it is clear that Auxiliary goals must be objective and meaningful. If we are to interest these persons in joining and serving, we must offer them an organization that is efficient and flexible, with activities that will mesh with their own schedules and interests. Along with these challenges, we must offer them sociability and friendship, which is easy with congenial, interesting and talented individuals.

Motives for Participation

Other motives for participation are: the desire for self-development and enrichment, the desire to exercise leadership and administrative talents and the desire to experience a variety of training opportunities. Future programming should offer career development for our

The Author

MRS. LINUS W. (JANE) HEWIT

Mrs. Hewit is the Chairman of the Long Range Planning Committee of the Florida Medical Association Auxiliary and Treasurer of the American Medical Association Auxiliary. She resides in Tampa.

younger members, so that while they support Auxiliary, they are improving their own skills.

Our projects must be carefully chosen and have realistic goals. With the cutbacks in government programs, there must be a massive revolution to moving back to caring for one another. Our capacity to care is the thing that makes Auxiliary a vital force in this revolution. Our impact on the communities we serve will depend on our expertise as volunteers. In order to improve our role as volunteers, we must realize that changes may be necessary, and innovation may be the only way to achieve them. So what if we rock the boat if, in doing so, we contribute to the health and progress of the organization? To remain unchanged and constant is to stagnate and drive the membership into seeking other avenues for using their time and talents.

New programs should be introduced regularly to give members alternatives. There should be something for everyone, with freedom of choice and flexibility of timing.

We must have a unified voice and collaborate more effectively within our own organization at all three levels: county, state and national, and with other groups whose objectives and goals compliment our own. As we consider new projects, every effort should be made to avoid fragmentation. A few goals, well-defined and accomplished, are far more meaningful than a number of not so successful ones.

Acceptance at All Levels

One change already recognized is the increased respect and acceptance of Auxiliary by the medical associations at all three levels. The Florida Medical Association realized what a strong right arm we give them and have made us an integral part of its organization. More and more county medical societies are inviting auxiliaries to sit on their key committees, and we have a strong working relationship with the American Medical Association. They are quick to admit that "we can do more together". Through a cooperative approach, staffs and members generate and share knowledge, conduct studies and are proving that interaction aids strength, as we endeavor to preserve, protect and promote better health for all people.

Another change here in Florida is the meeting of different cultures, as more foreign-born physicians come to this country for training and decide to remain. Their spouses affiliate with the Auxiliary, and bring cultural enrichment; they are eager to learn the "volunteer way" of serving in their adopted country. By accepting and understanding individuals from different national and cultural backgrounds, and by working together for common goals, our organization will add a new dimension. They need our support, training and encouragement, as they become accustomed to new ways in a strange land, and we must reach out to them. The privilege to be with people from different parts of the world, and exchange ideas, gives us a marvelous opportunity for growth. They provide a whole new enriching resource that must not be lost.

Fiscal responsibility is another area of concern, as we plan future programs of education and training for a more demanding and sophisticated membership. We must realize that meaningful programs, with learning opportunities, are most costly. We must encourage membership of those who, due to home or career responsibilities, have no time for service or attending meetings but can play a vital role by providing financial support. The Auxiliary cannot function properly in the future without these providers.

Retired Persons: A Resource

Also, a great resource in our state is the large number of retired persons who wish to keep in touch and serve the medical community, of which they have been a part all of their adult years. They make excellent volunteers, and we should pursue them!

The future of Auxiliary can be bright, if we join with our medical societies, and do all in our power to help people help themselves, cutting down on their dependence on the federal government. We must continue to sustain the endeavors of the medical profession by our involvement in health and health-related concerns. It is vital that we intensify our legislative activities and continue to be opinion makers. We must help with public enlightenment in such matters as health care cost containment and in developing a clearer understanding between the public and the medical community. We cannot afford apathy among our membership as we strive to overcome factors that have weakened our nation with a loss of social, moral and humanistic values. With the new



Jane Hewit presents the 1981 Peggy Wilcox Award to Gerry Gutierrez.

administration in Washington, we have a new direction, and we need a strong organization to help share the burden of rebuilding. We need total involvement at all levels.

Tapping All Resources

If Auxiliary is to continue to grow and provide the kind of organization that will be more effective in the future, we must tap all resources, research needs of both community and membership, and by careful planning, find the correct balance for all concerned. We must not ever be a voice in the wilderness but rather a concert of concerned citizens who can make a difference. The light at the end of the tunnel can become as bright as we wish it to be, providing new lustre for the profession we love and cherish.

To reach our full potential, we must have positive attitudes, strong leadership, determination, a willingness to affect change and a strong desire to grow. We must maintain a fresh and inviting organization in which our members can find their true worth as individuals. By joining together at all levels and as we face future challenges, our organization's role in the voluntary sector will become ever stronger and more encompassing. We must pursue excellence as we seek new horizons and face future challenges.

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Precautions: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

Adverse Reactions: Adverse reactions have been reported with specific vitamins and

5,000,000 hospital patients with infections.⁴ Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.³

The incalculable millions on calorie-reduced diets. Patients ingesting 1000 or fewer calories per day could be at high risk because this intake may not supply most nutrients in adequate amounts without supplementation.⁵



minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

Dosage and Administration: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.

How Supplied: Golden yellow, capsule-shaped tablets—bottles of 100.

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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Berocca Plus

A balanced formula for prophylactic or therapeutic nutritional supplementation.

Berocca Plus Tablets provide: therapeutic levels of ascorbic acid and B-complex vitamins; supplemental levels of biotin, vitamins A and E, and five important minerals (iron, chromium, manganese, copper and zinc); plus magnesium. Berocca Plus is not intended for the treatment of specific vitamin and/or mineral deficiencies.

Berocca Plus, highly acceptable to patients, has virtually no odor or aftertaste and is economical. And its "Rx only" status means more physician involvement, better patient compliance.

References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease*, op. cit., p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, op. cit., pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med* 89 (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

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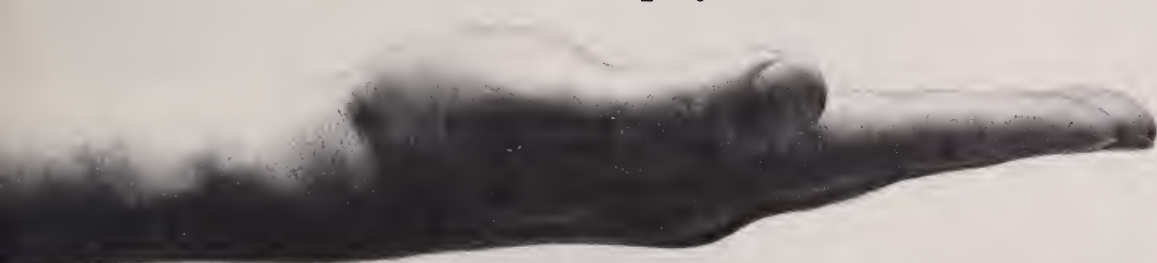
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Motrin[®] vs aspirin w/codeine...

(ibuprofen)

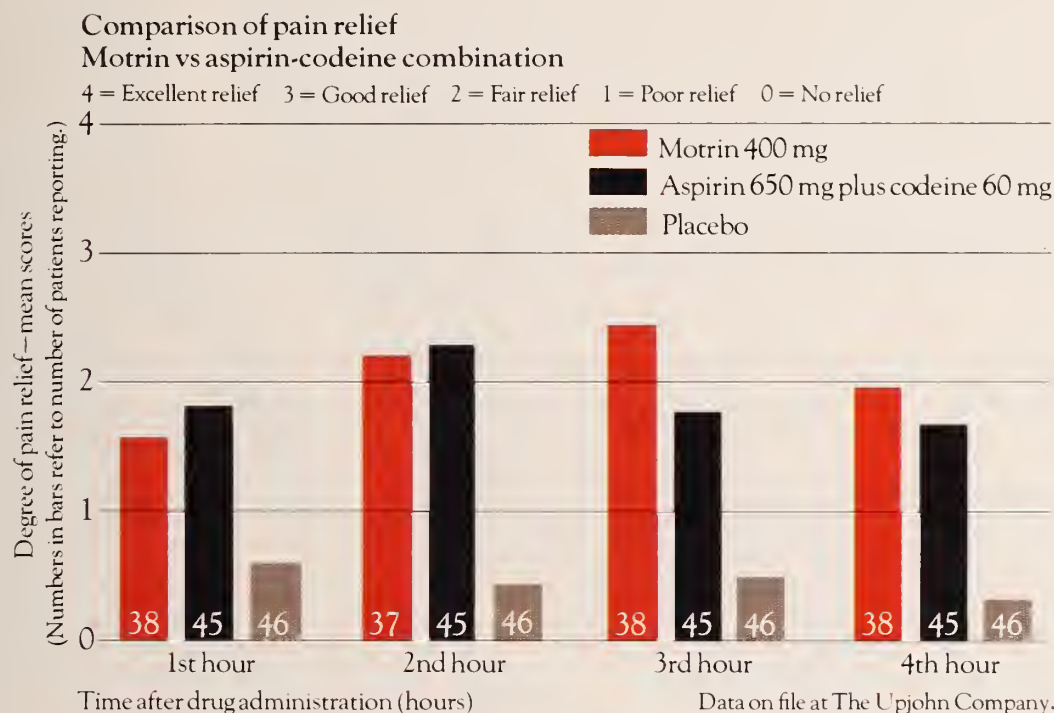


compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients.

In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval.

Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.



One tablet q4-6h prn
For relief of mild to moderate pain:

Motrin[®] 400mg TABLETS
ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming • Nonscheduled
- Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin[®] (ibuprofen)

now proved an effective analgesic for mild to moderate pain

Motrin[®] Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin.* Used concomitantly may decrease Motrin blood levels.

Coumarin. Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea, epigastric pain, heartburn, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness, headache, nervousness. **Dermatologic:** Rash (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena.

Central Nervous System: Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

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MED B-4-S

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It's a myth that arthritis is just the minor aches and pains of old age. It's a majorcrippler that attacks. Anybody. Anytime. 31 million Americans have it. There are almost a million new cases a year. And six out of ten are under 60. Symptoms can come and go for years. So if you don't know the warning signals, find out. If you'd like information that could help you—or you'd like to help us—write to the Arthritis Foundation, Box 19000, Atlanta, GA 30326.



Compared to ampicillin

Faster peak. Fewer problems.

... in adults and children

Cyclapen®-W (cyclacillin) produces peak serum concentrations* almost four times higher and over one hour earlier.³

Cyclapen®-W is just as effective in otitis media, bronchitis, pneumonia, urinary tract infections and infections of skin and skin structures†.³

Cyclapen®-W produces a significantly lower incidence of diarrhea and skin rash.³

CYCLAPEN®-W
(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.

*Rapidly excreted unchanged in urine. Clinical efficacy may not always correlate with blood levels.

†Due to susceptible organisms.

3. Data on file. Wyeth Laboratories.
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See important information on adjoining page.

Wyeth Laboratories
Philadelphia, Pa. 19101

Compared to amoxicillin

Faster peak. Fewer problems.

... in infants and children

Cyclapen®-W (cyclacillin) produces twice the peak serum concentration* (15.6 mcg/ml versus 7.3 mcg/ml) in half the time (30 minutes versus 60 minutes).¹

Cyclapen®-W is just as effective in otitis media and streptococcal tonsillopharyngitis†.²

Cyclapen®-W produces a significantly lower incidence of the most common side effect, diarrhea.²

CYCLAPEN®-W
(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.

*Rapidly excreted unchanged in urine.
Clinical efficacy may not always correlate with blood levels.

†Due to susceptible organisms.

1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.

2. Multicenter trials. Data to be published.

See important information on page after next.

Cyclapen®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine, Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY. Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.

†depending on severity

How Supplied Tablets 250 mg and 500 mg in bottles of 100. Oral Suspension 125 mg and 250 mg per 5 ml in bottles to make 100 ml and 200 ml of Suspension.

Wyeth Laboratories
Philadelphia, Pa. 19101



“When I dance, I feel better and beautiful.”

Melissa Berman is nine years old, deaf and a “natural dancer.” She takes ballet at the Joffrey Ballet School where Meredith Baylis teaches a special class for the non-hearing. The children respond to the vibration in the floor and sometimes get their instruction through an interpreter.

Dance seems to offer an escape valve for the remarkable energy that would otherwise be bottled up in Melissa and her classmates. Melissa's mother reports that when “The Nutcracker” appeared on television, Melissa got up and joined in the dancing. Melissa is also an accomplished gymnast but her great love is dance which she hopes to pursue.

Here in the dance studio, with the pianist pounding away, Melissa is indeed beautiful!

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NOTES AND NEWS

New Health Affairs Veep Named at Univ. of Fla.



Dr. Challoner

David R. Challoner, M.D., Dean of the St. Louis University School of Medicine since 1975, has been named Vice President for Health Affairs at the University of Florida.

University President Robert O. Marston, M.D., who announced the appointment, said Dr. Challoner, a specialist in endocrinology by training, would assume the position on July 1, succeeding Acting Vice Presi-

dent Kenneth Finger, Ph.D., who will return to his previous position as Associate Vice President.

"We are pleased to obtain a scientist and administrator with growing influence at the national level as our Health Center continues to gain increasing national and international stature," Dr. Marston remarked.

Dr. Challoner will be the principal administrator for the colleges of medicine, veterinary medicine, dentistry, nursing, pharmacy and health related professions as well as of the Shands Teaching Hospital. For several years the positions of Vice President for Health Affairs and Dean of the College of Medicine were occupied by a single person, first by the late Chandler A. Stetson, M.D., and then by William B. Deal, M.D., who continues to hold the position of Dean of the College of Medicine.

The decision was made to separate the two high-level positions in 1980.

The new Vice President is a native of Wisconsin and an honor graduate of Harvard Medical School, in the Class of 1961. He took internship and residency training at Columbia Presbyterian Hospital in New York City. He later took two years of research training at the National Heart Institute's Laboratory of Metabolism and an additional year as Chief Medical Resident at King County Hospital in Seattle, Wash.

Prior to joining the St. Louis University School of Medicine, Dr. Challoner served for four years as Chairman of the Department of Medicine at the Indiana University School of Medicine.

Dr. Challoner and his wife, Jacklyn, have a son, David, 22, and two daughters, Laura, 19 and Britt, 17.

USF Medical College Gets Endowed Chair

A national search has been launched for a leading cancer research scholar to fill a newly-established endowed chair at the University of South Florida College of Medicine.

According to Andor Szentivanyi, M.D., Dean of the College, the position will be known as the "George V. Cortner and Theodore J. Couch Endowed Chair in Cancer Research." Cortner and Couch are Tampa businessmen whose large gift to the University makes the endowed chair possible under Florida's 1979 Eminent Scholars Act. Under this legislation, the Legislature encouraged state universities to establish \$1 million endowed chairs by offering \$400,000 in State money to match every \$600,000 in private donations raised by the institutions.

The Couch and Cortner gift is "particularly noteworthy at this time because of the growth in cancer research at USF," University President John Lott Brown observed. USF and the State are currently developing plans for a \$63.5 million, 150-bed cancer and chronic disease research and treatment center adjacent to the College of Medicine. In addition, construction is expected to begin this year on a \$1.5 million cancer research facility within USF's new Research and Development Park.

Pensacola Native Becomes Editor of Journal of AMA

George D. Lundberg, M.D., a native of Pensacola, Fla., became Editor of *The Journal of the American Medical Association* on January 1. Dr. Lundberg, 48, also will serve on the AMA staff as Vice President for Scientific Information.

Dr. Lundberg, who succeeds William R. Barclay, M.D., as *JAMA* Editor, comes to the AMA from the University of California School of Medicine at Davis, where he was Chairman of the Department of Pathology. Dr. Barclay retired on December 31.

The new Editor received his M.D. degree from the Medical College of Alabama. He had been a member of the *JAMA* editorial board since 1973.

Dr. Alberto M. Hernandez To Head Medical Examiners



Dr. Hernandez

Alberto M. Hernandez, M.D., of Coral Gables, has been elected Chairman of the Florida State Board of Medical Examiners, the first Cuban-American to hold that position. He was elected at the Board's meeting in St. Petersburg on Dec. 6 to succeed Robert Webster, M.D., of Tallahassee.

A graduate of the University of Havana School of Medicine, Dr. Hernandez is a Diplomate of the American

Board of Family Practice. He is a member of the American Academy of Family Physicians and of the Dade County, Florida and American medical associations.

He has been a member of the Board of Medical Examiners since 1979.

Florida Medical Assn. Announces Two Awards

Awards programs in medical speaking and in malpractice prevention have been announced by the Florida Medical Association.

The current FMA Annual Program for Medical Speakers includes talks given on behalf of FMA county medical societies between January 1 and December 31, 1981. A plaque and \$100 cash award will be made in each of the following categories: television news show; television talk show; radio news or talk show guest; TV or Radio host; public (lay) audience talk; and professional audience talk.

Entries must be postmarked no later than March 12, 1982.

Any physician member of the Florida Physicians' Insurance Reciprocal or team of physicians or hospital administrators or risk managers, clinic managers, or other individuals who during the year presented timely programs, produced a publication or offered help in the defense of a physician under possible malpractice threat is eligible to compete for the FMA Malpractice Prevention Award if nominated by a county medical society. Entries must be mailed by February 26.

Information and application forms about the two programs may be obtained by contacting the Florida Medical Association Department of Communications, P.O. Box 2411, Jacksonville, Florida 32203.

Two State Hospitals Accredited for CME

The FMA Committee on Medical Education has accredited two more community hospitals in Florida as providers of continuing medical education.

Committee Chairman Henry M. Yonge, M.D., of Pensacola, identified the newly-accredited hospitals as Winter Haven Hospital, Inc., Winter Haven; and North Ridge General Hospital, Inc., Fort Lauderdale. He said both hospitals were granted provisional accreditation for two years, retroactive to the dates the hospitals were visited by survey teams.

Provisional accreditation is routine in the cases of hospitals being approved for the first time, according to Dr. Yonge.

Accreditation of the two hospitals were granted under authority delegated to the Florida Medical Association by the national Accreditation Council for Continuing Medical Education. As accredited providers, the two hospitals may certify their own programs as acceptable for AMA Category I Credit, if appropriate.

Dr. Yonge also announced that the Committee on Medical Education of the Florida Medical Foundation was reaccredited for a six-year period.

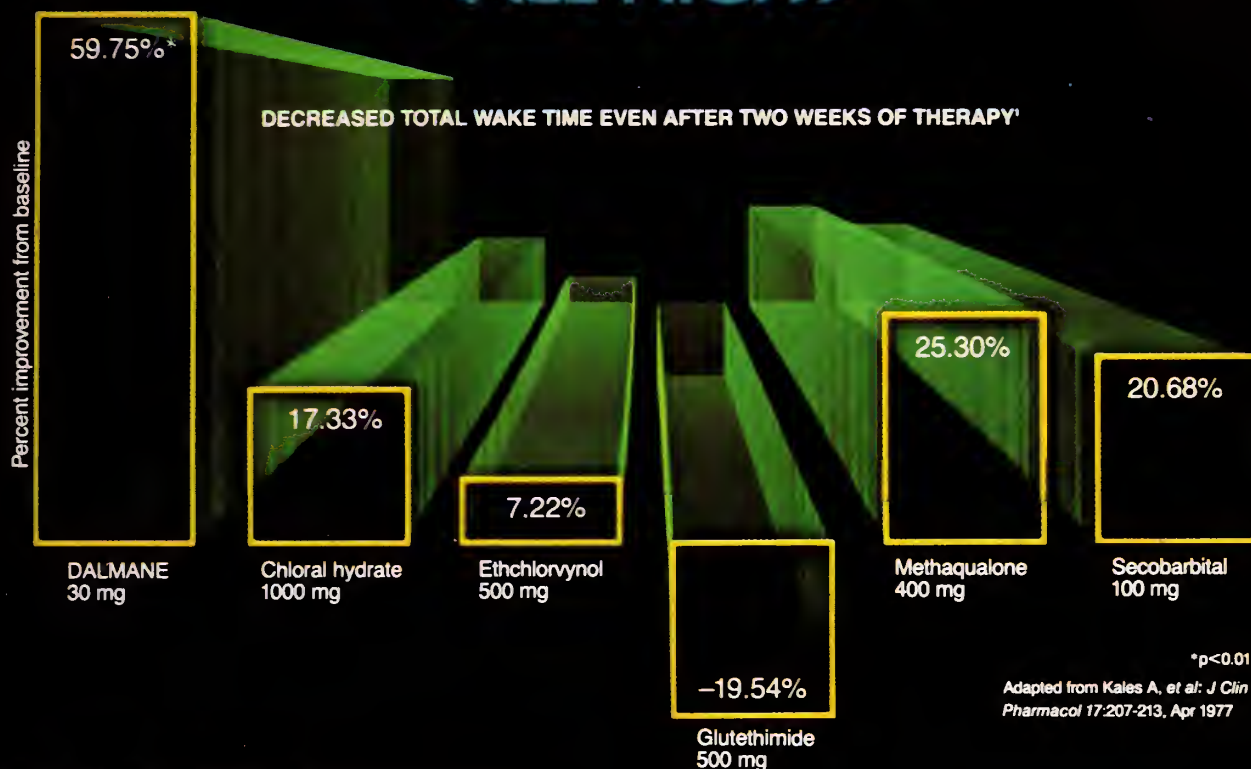
Three Florida Faculty Get National Posts

William B. Deal, M.D., Dean of the University of Florida College of Medicine, has been named to the Administrative Board of the Association of American Medical Colleges' Council of Deans. His election took place at the 1981 Annual Meeting of AAMC in Washington.

Meanwhile, the election of two other members of the faculty at the University of Florida College of Medicine to offices in national organizations was announced.

James L. Talbert, M.D., Professor of Surgery and Chief of Pediatric Surgery, was elected to a two-year term on the Executive Committee of the American College of Surgeons. Also, William Stewart, M.D., Professor and Chairman of the Department of Community Health and Family Medicine, is the new President of the Association of Departments of Family Medicine, a subsidiary of the Association of American Medical Colleges.

EFFECTIVE ALL NIGHT



WITH AN UNSURPASSED RECORD OF EFFICACY AND SAFETY

The efficacy of Dalmane (flurazepam HCl/Roche) has been documented in 185 studies involving 9141 patients suffering from one or more of the three major forms of insomnia—difficulty falling asleep, staying asleep and sleeping long enough.²

Relative safety was demonstrated in a large study of 2542 hospitalized medical patients. Only 3.1% of these patients reported adverse reactions—predominantly unwanted residual drowsiness. None of the reactions were considered serious by attending physicians.³

FOR SLEEP WITHIN 17 MINUTES² AND NO WORSENING OF SLEEP ON DISCONTINUATION

Rapid sleep induction, within 17 minutes on average, sets the stage for insomnia relief. And, after discontinuation of Dalmane for periods ranging up to 14 nights, no worsening of sleep compared with baseline was observed.⁴

Should insomnia recur, the patient may require guidance in setting up a regular sleep program to help

provide the optimum environment for the onset of natural sleep. If hypnotic therapy is required, it should be given for the shortest time at the lowest effective dose to achieve the desired goal.

Consider other medications the patient may be taking (including alcoholic beverages) and be aware of possible drug interactions. Please note that patients should be treated for underlying physical or psychological factors before therapy with a sleep medication is undertaken.

DALMANE[®] ^{IV}
flurazepam HCl/Roche
**THE STANDARD OF HYPNOTIC EFFICACY
FROM THE LEADER IN SLEEP RESEARCH**



Please see reverse side for a summary of product information.



SLEEP-SPECIFIC **DALMANE**[®] flurazepam HCl/Roche

One 15-mg capsule h.s.—recommended initial dosage for elderly or debilitated patients.

One 30-mg capsule h.s.—usual adult dosage (15 mg may suffice in some patients)

THE STANDARD FOR HYPNOTIC EFFICACY WITH IMPORTANT ADDED BENEFITS

- Well tolerated²
- No chemical interference with many commonly ordered laboratory tests, including triglycerides, uric acid, glucose, SGOT, alkaline phosphatase and total protein^{5,6} (See adverse reactions section of complete product information.)
- Compatible with chronic warfarin therapy; no unacceptable fluctuation in prothrombin time reported^{7,8}

UNLIKE NONSPECIFIC MEDICATIONS USED FOR SLEEP

Tricyclic antidepressants

- which are *not* sleep specific,⁹ yet are sometimes used in nondepressed patients for sleep
- which can cause transient insomnia in the elderly¹⁰
- which can require careful monitoring in cardiovascular patients¹⁰
- which have strong anticholinergic effects¹⁰

Antihistamines

- which are *not* reliable sleep-inducing agents¹¹
- which may produce stimulation instead¹¹
- which have anticholinergic effects¹¹

Major tranquilizers

- whose side effects may be troublesome for nonpsychotic patients¹²
- where tolerance for sedation appears rapidly¹²

Dalmane does not cause significant worsening of sleep beyond baseline levels upon discontinuation.⁴

References: 1. Kales A, et al. *J Clin Pharmacol* 17:207-213, Apr 1977 2. Data on file. Medical Department, Hoffmann-La Roche Inc., Nutley NJ 3. Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther* 21:355-361, Mar 1977 4. Kales A, et al. *Clin Pharmacol Ther* 18:356-363, Sep 1975 5. Moore JD, Weissman L. *J Clin Pharmacol* 16:241-244, May-Jun 1976 6. Spiegel HE. Data on file. Medical Department, Hoffmann-La Roche Inc., Nutley NJ 7. Robinson DS, Amidon EL. Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York: Raven Press, 1973, pp 641-646 8. Warfarin Study. Data on file. Medical Department, Hoffmann-La Roche Inc., Nutley NJ 9. Baldessarini RJ. Drugs and the treatment of psychiatric disorders, chap 19, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co. Inc., 1980, pp 391-447 10. Cole JO, Davis JM. Antidepressant drugs, chap 31.2, in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore: The Williams & Wilkins Company, vol 2, 1976, pp 1941-1956 11. Douglas WV. Histamine and 5-hydroxytryptamine (serotonin) and their antagonists, chap 26, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co. Inc., 1980, pp 609-646 12. Davis JM, Cole JO. Antipsychotic drugs, chap 31.1, in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore: The Williams & Wilkins Company, vol 2, 1976, pp 1921-1940

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.

Adults: 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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MEETINGS

Accepted by the FMA Committee on Medical Education for Mandatory Credit

MARCH

Basic Neurology for Psychiatrists and Generalists: A Comprehensive Review Course, Mar. 1-5, Miami. For information: University of Miami School of Medicine, Dept. of CME, P.O. Box 016960, Miami 33101.

Postgraduate Medical Refresher Course, Mar. 1-12, Fort Lauderdale. For information: Charles E. Aucremann, M.D., 7300 Demens Dr. South, St. Petersburg 33712.

Current Clinical Concepts in Otolaryngology 1982, Mar. 3-4, Miami. For information: University of Miami School of Medicine, Dept. of CME, P.O. Box 016960, Miami 33101.

Comprehensive Review in Toxicology, Mar. 4-6, Orlando. For information: Charles E. Aucremann, M.D., 7300 Demens Dr. South, St. Petersburg 33712.

Health Care of the Elderly: A Challenge to Medicine, Mar. 4-6, Tampa. For information: Johanna Newton, Suncoast Gerontology Center, University of South Florida Medical Center, Box 50, 12901 N. 30th St., Tampa 33612.

Peripheral Vascular Disease Symposium, Mar. 5, Daytona Beach. For information: Jack E. Arrants, M.D., Memorial Hospital, (904) 677-6900.

Pan American Symposium on Cancer of the Head and Neck, Mar. 5-6, Miami. For information: University of Miami School of Medicine, Dept. of CME, P.O. Box 016960, Miami 33101.

Internal Medicine 1982, Mar. 7-12, Miami Beach. For information: J. S. Bocles, M.D., P.O. Box 016960, Miami 33101.

17th Annual Postgraduate Course in Internal Medicine, Mar. 7-12, Bal Harbour, Fla. For information: J. S. Bocles, M.D., P.O. Box 016960, Miami 33101.

14th Annual Teaching Conference in Clinical Cardiology, Mar. 10-13, Bal Harbour, Fla. For information: Michael Gordon, M.D., P.O. Box 016960, Miami 33101.

Family Practice Grand Rounds, Mar. 10, 24, Jacksonville. For information: Mary P. Kellogg, M.D., 655 W. 8th St., Jacksonville 32209.

Problems in Rheumatology, Mar. 11-14, St. Petersburg. For information: Bernard F. Germain, M.D., Box 19, University of South Florida College of Medicine, Tampa 33612.

Symposium on Glaucoma: Patient Evaluation, Surgical and Laser Therapy, Mar. 12, Gainesville. For information: JHM Health Center, Box J-233, Gainesville 32610.

Basic Science in Dermatology, Mar. 13, Boca Raton. For information: Kenneth A. Mehr, M.D., Secretary, Palm Beach County Dermatological Society, 900 N.W. 13th St., Suite 301, Boca Raton 33432.

Intensive Care for Neurological Disease and Trauma, Mar. 14-18, Kissimmee, Fla. For information: Gloria Allington, P.O. Box 016960, Miami 33101.

13th Annual Topics in Internal Medicine, Mar. 18-20, Gainesville. For information: JHM Health Center, Box J-233, Gainesville 32610.

St. Moritz 1982 — Advances in Diagnostic Imaging, Mar. 21-28, Moritz, Switzerland. For information: Edward A. Eikman, M.D., 3100 East Fletcher Ave., Tampa 33612.

Orthopaedics for Family and Emergency Physicians, Mar. 24-27, Lake Buena Vista, Fla. For information: Allan W. March, M.D., JHMH, Box J-222, Gainesville 32610.

Nutrition in Chronic Disease, Mar. 25, Tampa. For information: Jay J. Mamel, M.D., 12001 N. 30th St., Tampa 33612.

Postgraduate Course on Interesting Topics in Orthopedics — 1982, Mar. 25-27, Palm Beach Gardens. For information: Michael S. Zeide, M.D., 2501 N. Flagler Drive, West Palm Beach 33407.

Advances in the Treatment of Coronary Artery Disease, Mar. 26, 27, Pensacola Beach. For information: Charles P. Riley, M.D., (904) 477-5029, 434-1093.

ECG Interpretation and Arrhythmia Management, Mar. 26-28, St. Petersburg. For information: Stephen E. Mattingly, (800) 525-8651.

Practice Update in Obstetrics and Gynecology, Mar. 31-Apr. 2, Kissimmee, Fla. For information: Amelia C. Cruz, M.D., Dept. of Ob/Gyn, University of Florida College of Medicine, Gainesville 32610.

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APRIL

Fifteenth Family Practice Review, Apr. 5-9, Kissimmee, Fla. For information: University of Florida College of Medicine, Box J-233, Gainesville 32610.

Comprehensive Review Course for ECFMG, FLEX and VQE (in Spanish), April 5-July 16, Miami. For information: Rafael Penalver, M.D., University of Miami, P.O. Box 016960, Miami 33101.

Spinal Surgery: A Combined Neurosurgery and Orthopedic Advanced Course, Apr. 5-9, Miami Beach. For information: Dept. of Orthopedics and Rehabilitation, University of Miami School of Medicine, P.O. Box 016960, Miami 33101.

Clinical Management of Coronary Disease and Exercise Testing, Apr. 16-18, Orlando. For information: Charles E. Aucremann, M.D., 7300 Demens Dr. South, St. Petersburg 33712.

New Developments in Inhalation Anesthesia and Clinical Application in Special Situations, Apr. 24-25, Howard Johnsons Hotel, Pensacola Beach. For information: Warren W. Sears, M.D., 1717 N. "E" Street, Suite 205, Pensacola 32501.

Health Promotion: The Payoff of Business and Industry, Apr. 26-30, Palm Coast. For information: Sue Antonovitz (219) 392-7151.

MAY

Third Annual Advanced Cardiac Life Support for Physicians, May 7-8, Cedars of Lebanon Health Care Center, Miami. For information: Debbie Zayas, 1400 N.W. 12th Ave., Miami 33136.

Master Approach for Cardiovascular Problems, May 29-June 1, Walt Disney World, Fla. For information: Louis Lemberg, M.D., Dept. of Cardiology, University of Miami School of Medicine, Box 016960, Miami 33101.

JUNE

Cardiology for the Practitioner, June 4-11, Mississippi Queen Steamboat Cruise. For information: Lamar Crevasse, M.D., University of Florida College of Medicine, Box J-233, Gainesville 32610.

Annual Homecoming in Psychiatry, June 11-12, Miami. For information: University of Miami, Dept. of Psychiatry, P.O. Box 016960, Miami 33101.

18th Annual Resident's Day in Ophthalmology, June 19-21, Key Biscayne, Florida. For information: Gaby Kressly, Dept. of Ophthalmology, University of Miami, P.O. Box 016960, Miami 33101.

Conference on Reyes Syndrome, June 25, USF College of Medicine, Tampa. For information: Dr. R. Fernandez, 12901 N. 30th Street, Box 15, Tampa 33612.

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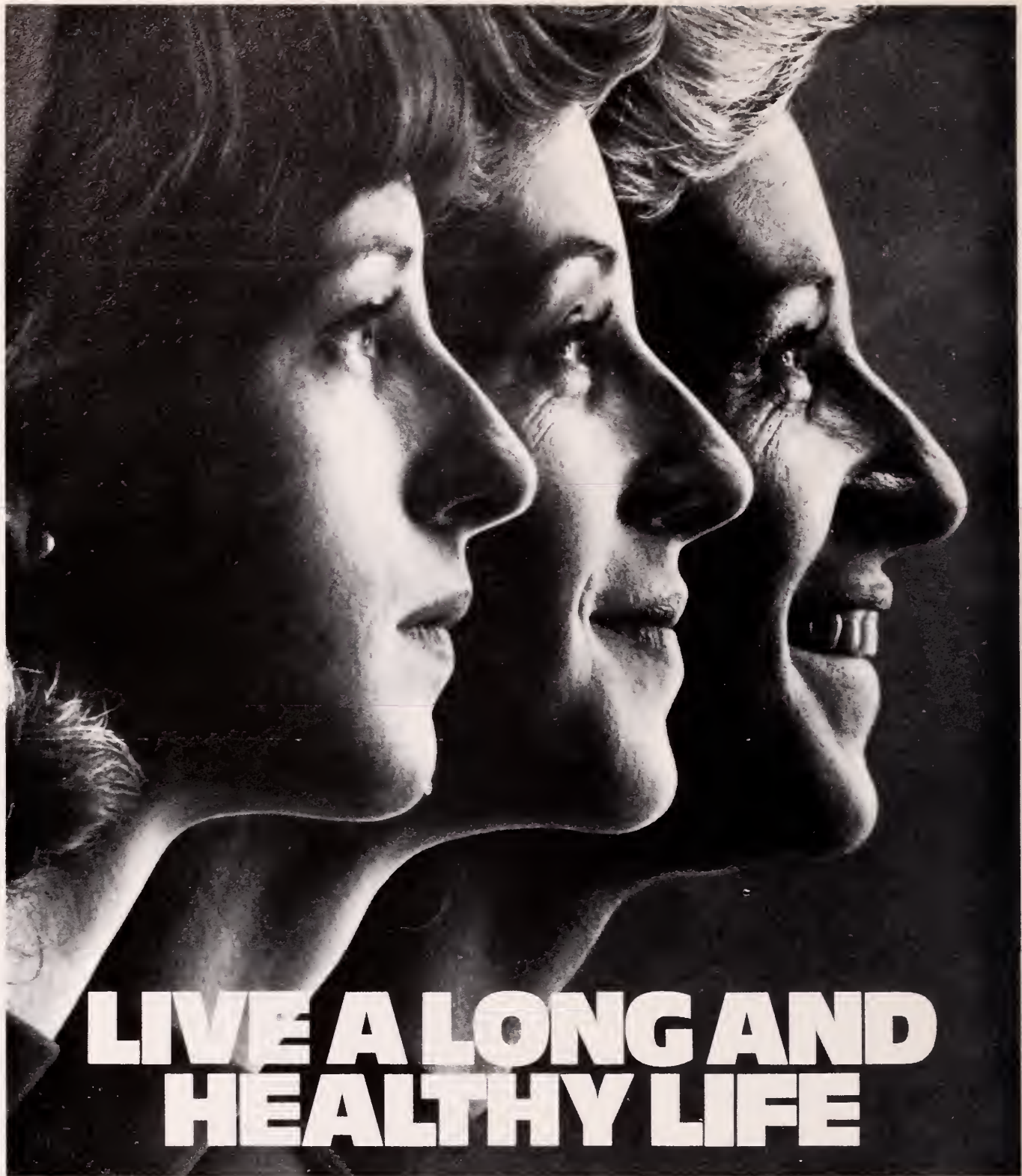
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"HEALTH PROMOTION: The Pay-off for Business and Industry," a conference designed to provide business leaders and health professionals with information on why health promotional activities are important and how these programs are best planned, organized and developed. April 26-30, 1982, Sheraton Palm Coast Resort, Palm Coast, FL. (219) 392-7151.

10-DAY NON-MEDICAL CARDIAC TREATMENT PROGRAM — Diet, exercise, stress management, and cognitive restructuring of type A's for post myocardial infarction patients and persons seen as "at risk" by their physicians. Scenic hunting lodge in Smoky Mountains — not a resort. Accepting referrals for 1982 season — \$2,700 total. For information: Institute for Improved Living, P.O. Box 478, Dillsboro, N.C. 28725, Telephone: 1-704-258-4580.

Classified advertising rates are \$10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

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MAY 5 - 9, 1982**

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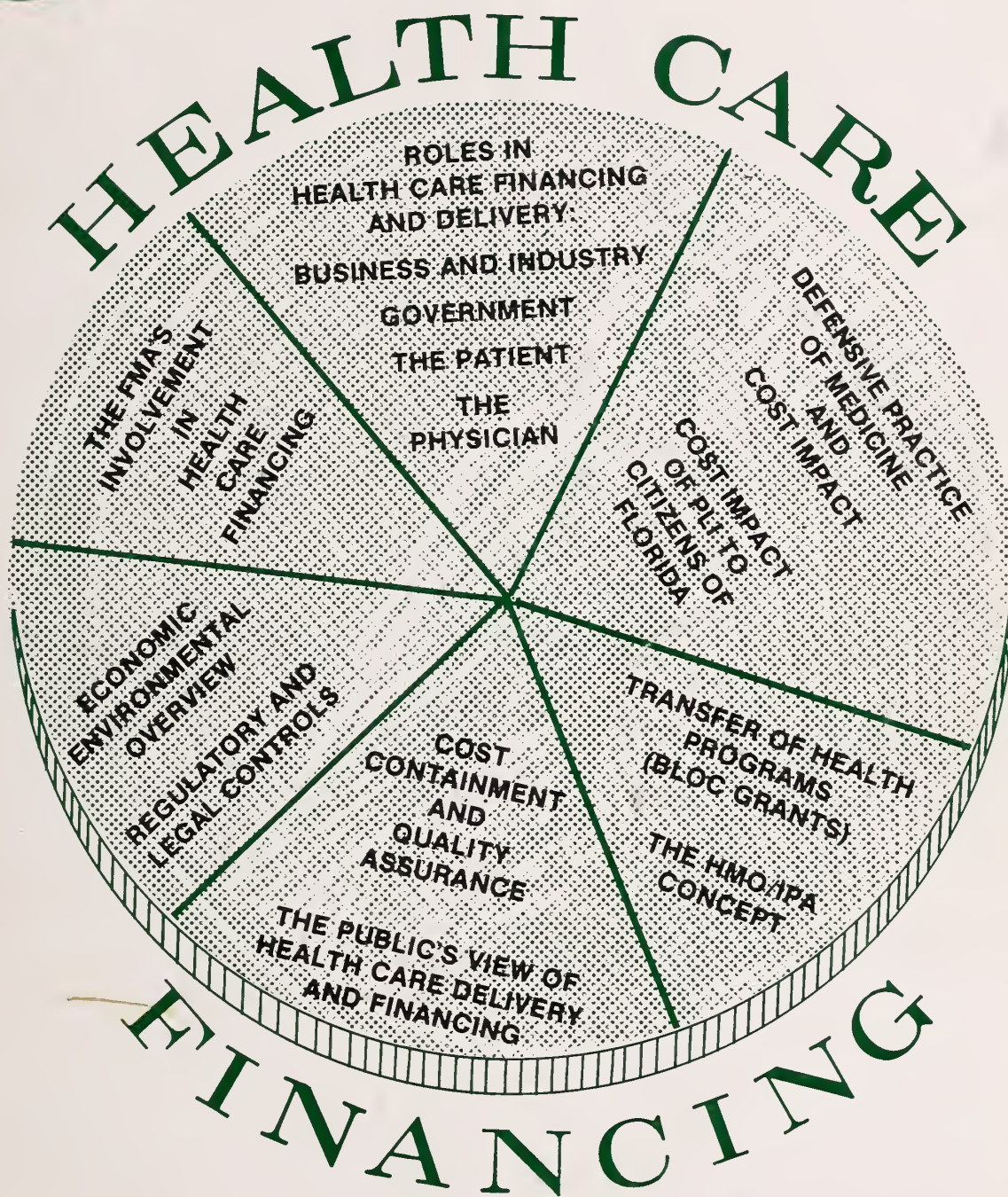
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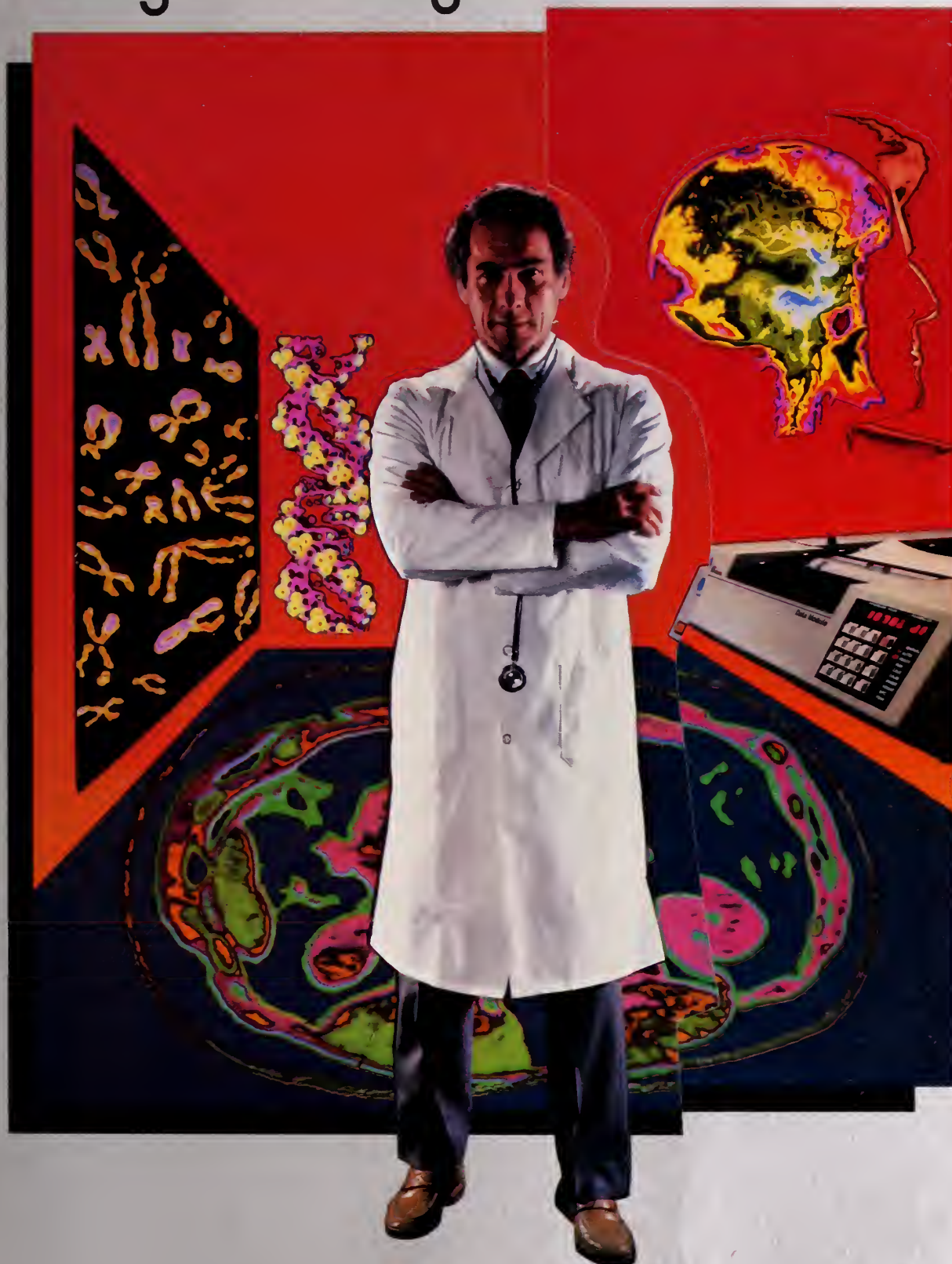
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In an era of change,
An Agent of Change...





Ativan®: Agent of Change

(lorazepam)

Your patients are changing

the population is getting older, more people are holding a second job, patients are more concerned about the medications they take

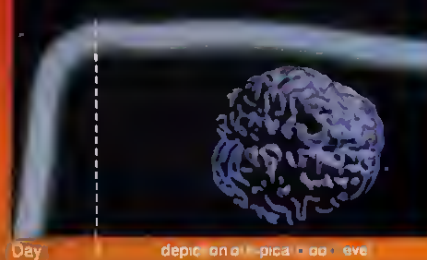
Medical knowledge is changing

there are diagnostic resources and surgical techniques undreamed of only a few years ago, biomedical engineering, new insights also into the action of drugs

In this changing environment, the way you are practicing medicine is changing too...

Twenty years ago, the benzodiazepines represented a real step forward in the management of anxiety and tension states. In recent years, however, concern about drug accumulation and clearance has led physicians to re-evaluate their use of these agents. In light of current knowledge, many clinicians are changing from multi-metabolite benzodiazepines to Ativan® (lorazepam)—a metabolically and pharmacokinetically distinctive agent that offers clinical advantages which more closely meet the expectations of a modern anxiolytic.

Ativan: Accumulation to steady state extends for only 2-3 days. No active metabolites.



because...

it's shorter acting, with less accumulation*

In contrast to long-acting benzodiazepines, Ativan has a short, 12-hour half-life, and no active metabolites. In multiple-dose therapy, Ativan accumulates for only two to three days before reaching steady state, the long-acting benzodiazepines—diazepam CIV, chlordiazepoxide CIV, clorazepate CIV and prazepam CIV—with their active metabolites—accumulate for as long as 20 days, increasing the likelihood of excessive sedation.

it doesn't interact with drugs metabolized by P450 microsomal enzymes

Most benzodiazepines undergo oxidative metabolism and thus utilize the hepatic microsomal enzyme system. Ativan® (lorazepam), however, is metabolized by glucuronidation and does not compete with other drugs for cytochrome P450. Thus, when Ativan is given with Tagamet® (cimetidine), for example, clearance is not delayed, nor sedation increased*—unlike reported observations with patients on other benzodiazepines¹⁻⁵.

it gives you greater control of therapy


The short half-life of Ativan® facilitates more rapid response to dosage adjustments, allowing you to titrate therapy to patients' changing needs. Also, once you decide to discontinue Ativan, it will be out of your patient's system four days after the final dose—in contrast to long-acting benzodiazepines and their active metabolites which take as long as two weeks to be totally eliminated.

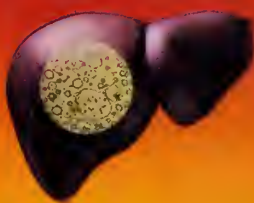
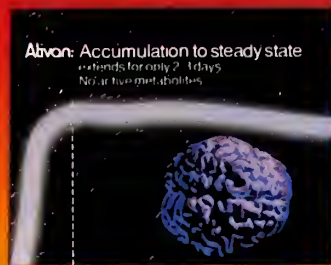
Ativan®
for (lorazepam) IV
Anxiety

See important information on following page

1. Klotz U, Reimann I. N Engl J Med 302:1012-1014, 1980.
2. Desmond PV, Patwardhan RV, Schenker S, et al. Ann Intern Med 93:266-268, 1980.
3. Patwardhan RV, Yarborough GW, Desmond PV, et al. Gastroenterology 79:912-916, 1980.
4. Sellers EM, Naranjo CA, Peachey JE. N Engl J Med 305:1255-1262, 1981.
5. Ruffalo RL, Thompson JF, Segal JL. South Med J 74:1075-1078, 1981.
*Pharmacokinetics cannot as yet be directly related to efficacy.
†All benzodiazepines produce additive effects when given with CNS depressants such as barbiturates or alcohol.

Ativan®: Agent of Change

(lorazepam) 



- Little accumulation lessens likelihood of excessive sedation
- Unlike most benzodiazepines, Ativan does not compete with other drugs, such as Tagamet® (cimetidine), for the microsomal enzyme system during biotransformation
- Metabolism not affected by age or liver dysfunction
- Short half-life provides greater control of therapy
- Promptly eliminated from patient's system after discontinuation
- Specifically evaluated and found effective for anxiety associated with cardiovascular and gastrointestinal disorders
- A distinctive change from long-acting benzodiazepines, all of which have active metabolites and are much the same

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia, some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levaterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Dosage: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

How Supplied: 0.5, 1.0 and 2.0mg tablets.

Wyeth Laboratories Philadelphia, PA 19101



GRAYPAPER



HEADQUARTERS / 760 RIVERSIDE AVENUE / BOX 2411 / JACKSONVILLE, FLORIDA 32203 / (904) 356-1571
W. HAROLD PARHAM, D.H.A., EXEC. VICE PRES. / DONALD C. JONES, EXEC. DIRECTOR

No. 82-1

February 26, 1982

THE FLORIDA PATIENTS' COMPENSATION FUND IS SHORT OF FUNDS TO SETTLE CLAIMS.

The first assessment of \$1,350,672 for year 1978 had not been billed before a request was made and approved of \$13,935,927 for year 1979. According to information from John W. Odem, FPCF General Manager, their latest actuary study shows the fund to need \$177 million to pay claims incurred through year 1981. With income projected at \$55 million, this is a shortfall of \$122 million that will come through assessments, the first two having just been made. Physicians will be assessed 100% of their 1979 original fee, approximately \$2,400,000 and hospitals will pay up to 204% of their original fee, approximately \$11,480,000 assessment for year 1979. There appears to be many more assessments in the works. In order to get income in line for future years, the FPCF Actuary has suggested a rate increase effective year 1982-83 over year 1981-82, of 241% for Class 1 and 2 physicians, 255% for Class 3 physicians and hospital rates would increase 130% per bed. A Class 3 physician in Dade or Broward would increase from \$4,323 to \$11,022 for excess over \$100,000. Additional assessments plus future rate increases appear to be imminent.

SIXTEEN MORE MEDICAL MALPRACTICE PREVENTION SEMINARS ARE PLANNED FOR 1982.

To date, over 6,700 physicians have attended 46 such seminars throughout Florida on a regional basis and have found them to be both interesting and informative. The Florida Physicians' Insurance Reciprocal has found the seminars a most worthy tool in making physicians more defensible when claims arise. Please check the schedule which follows for those in your practice area, or contact the Risk Management Department of PIMCO for additional information.

FEBRUARY 19, 1982 — University of Miami School of Medicine — Miami

Medical Science Building Auditorium — 1601 Northwest 10th Avenue, Miami, Florida
9:00 a.m. - 12:00 noon

MARCH 4, 1982 — Palm Beach County Medical Society — Lake Worth

Palm Beach Junior College, Allied Health Building — 4200 Congress Avenue, Lake Worth, Florida
1:30-4:30 p.m. and 6:30-9:30 p.m.

APRIL 29, 1982 — Escambia County Medical Society — Pensacola

Baptist Hospital, Medical Meeting Room — 1000 West Moreno, Pensacola, Florida
1:30-4:30 p.m. and 6:30-9:30 p.m.

MAY 6, 1982 — Florida Medical Association Annual Meeting

Diplomat Hotel — Hollywood Beach, Florida
4:30-6:30 p.m.

JUNE 3, 1982 — Hillsborough County Medical Association — Tampa

Holiday Inn — 4500 West Cypress, Tampa, Florida
1:30-4:30 p.m. and 6:30-9:30 p.m.

— more —

FMA

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JULY 1, 1982 — Orange County Medical Society — Orlando
Loch Haven Art Center — 2416 North Mills Avenue, Orlando, Florida
1:30-4:30 p.m. and 6:30-9:30 p.m.

AUGUST 19, 1982 — Broward County Medical Association — Ft. Lauderdale
Meeting Place Not Yet Determined
1:30-4:30 p.m. and 6:30-9:30 p.m.

SEPTEMBER 23, 1982 — Sarasota County Medical Society — Sarasota
Meeting Place Not Yet Determined
1:30-4:30 p.m. and 6:30-9:30 p.m.

NOVEMBER 19, 1982 — Capital Medical Society — Tallahassee
Silver Slipper (To Be Confirmed)
1:30-4:30 p.m. and 6:30-9:30 p.m.

TWO NEW FMA SPONSORED PLANS ARE BEING OFFERED BY THE FLORIDA MEDICAL Insurance Trust. The Disability Income Replacement Plan provides benefits of up to \$7,000 per month which may be collected while still engaged in the practice of medicine. A new Retired Lives Reserve Plan (RLR) enables a doctor to continue his term insurance after retirement with tax-exempt funds set aside during his active years of practice. Since PIMCO began administration of the FMIT plans June 1, 1981, over 5,800 members have enrolled. Among the advantages are lower cost due to self-funding, lower administrative costs and the fact coverage is controlled by FMA. New FMA members are eligible for all FMIT programs with no underwriting restrictions during the first 90 days of their membership. All other members may enroll at any time with limited restrictions. For more information about these and other FMA sponsored insurance programs, contact PIMCO, P.O. Box 40198, Jacksonville, Florida 32203, (WATS) 1-800-342-8349.

THE CANDIDACY OF RUFUS K. BROADAWAY, M.D., MIAMI, FOR THE OFFICE OF AMA TRUSTEE has the enthusiastic support of FMA's Board of Governors. All of Dr. Broadaway's peers who know and have had the pleasure of working with him over the years are fully aware of his many qualifications for this important position to be decided at the Annual AMA Meeting in June. All FMA members who are personally acquainted with delegates from other states to the AMA are encouraged to solicit their support in Dr. Broadaway's behalf. Your personal contact, preferably by telephone, will be greatly appreciated.

MANY PHYSICIANS ARE STILL NOT AWARE OF THE CONFIDENTIAL HOT LINE FOR FMA'S Impaired Physician Program. If you, or a physician you know, have an alcohol or other drug related problem call, day or night, (305) 667-8717. A number of talented physicians are resuming their practices as a result of the program and the caring and sharing of their peers.

DETAILED INFORMATION HAS BEEN SENT TO THE ENTIRE MEMBERSHIP REGARDING THE FMA Annual Meeting to be held May 5-9 at the Diplomat Hotel. Those county medical societies wishing to reserve suites are requested to contact Don Jones at the earliest possible date.

A TWO-HOUR SEMINAR ON THE PROCESS OF AGING WILL KEYNOTE THE THEME OF THE Scientific Program for the 108th Annual Meeting of the Florida Medical Association May 5-9, 1982 at the Diplomat Hotel, Hollywood, Florida. Three nationally known experts on the aging process will speak at the program on Thursday afternoon, May 6. Calvin W. Martin, M.D., of Arcadia, Chairman of the Subcommittee on Annual Meeting Scientific Programs, says the following guest speakers will be featured: Robert D. Terry, M.D., Professor and Chairman of the Department of Pathology, Albert Einstein College of Medicine, Bronx, N.Y.; Eugene Stead, M.D., Professor of Medicine, Duke University School of Medicine, Durham, N.C.; and Eric Pfeiffer, M.D., Director of the Suncoast Gerontology Center, Tampa.

THE SIXTEENTH ANNUAL BENEFIT ART SHOW SPONSORED BY THE FMA AUXILIARY WILL BE held during the Annual Meeting. Physicians, their spouses and children will be eligible to enter. Rules and entry blanks will be published in the March and April issues of *The Journal*.

THE SECOND ANNUAL "BENT INSTRUMENT AND LOST BALL" GOLF OUTING HAS BEEN scheduled for Thursday, May 6, at Bonaventure Country Club near Fort Lauderdale. There will be a shotgun start at 1:00 p.m., with the field limited to a maximum of 80 players. Entry forms will be enclosed in the next issue of the *Briefs* which will be published in the immediate future. Cost of the tournament per individual player will be \$31 which includes a reception and an awards ceremony at the Bonaventure Club after play is completed.

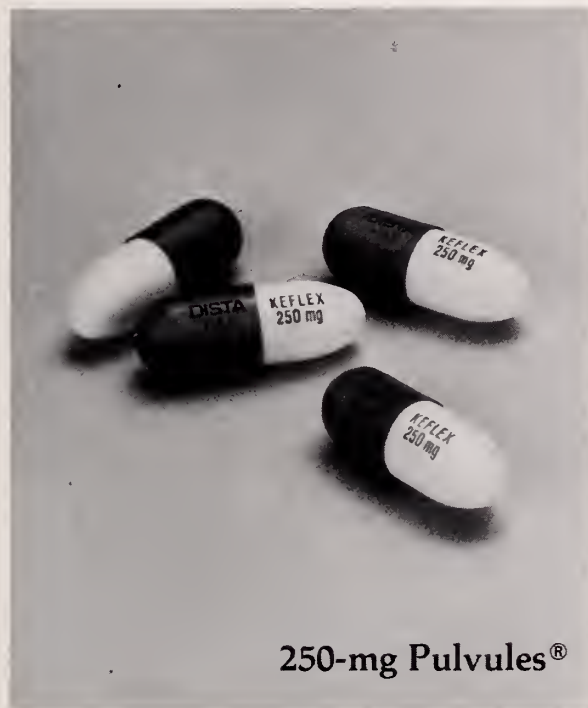
THE FMA WILL SPONSOR ITS FOURTH 5,000 METER (3.1 MILE) "HEALTH RUN FOR FUN" ON Saturday, May 8, 1982, as part of the 108th Annual Meeting activities. The run will begin at 7:30 a.m. and will follow a course along the Hollywood Boardwalk. All physicians, their families, and guests attending the Annual Meeting are invited to participate. Specially designed T-shirts will be presented to all participants. There will be a \$5.00 entry fee, which includes the cost of the T-shirt. Health Run packets can be picked up at the annual meeting registration desk on Wednesday, Thursday, and Friday. The deadline for registration is 4:30 p.m. on Friday, May 7.

FMA'S HOUSE OF DELEGATES CHARGED WITH POLICY-MAKING FOR THE ORGANIZATION will meet three times during the Annual Meeting with the first session scheduled for Wednesday afternoon, May 5, at 4:30 p.m. During the opening session, the House will formally receive reports, resolutions, recommendations and other items of business. All items of business to be considered will be assigned to one of five reference committees which will hold hearings and formulate their own recommendations on Thursday, May 6. The reports of the reference committees will be considered by the full House during sessions beginning at 3:00 p.m. on Saturday, May 8, and 9:00 a.m. on Sunday, May 9. House Speaker James B. Perry, M.D., of Fort Lauderdale, and Vice Speaker Franklin B. McKechnie, M.D., of Winter Park, will preside over the activities of the House. Component county medical societies are reminded of the following procedures for resolutions to be considered by the House of Delegates:

- The *Handbook* for Delegates will contain all the reports and resolutions to be considered by the House which have been received as of the date of publication (April 1).
- If your county society has resolutions which it wishes published in the *Handbook*, please forward them to the FMA Headquarters Office **no later than March 29**.
- Any resolutions after that date will be duplicated and included in the delegates packets, which will be distributed to the delegates during registration.
- The absolute deadline for receiving resolutions to be considered during the 1982 House of Delegates is 12:00 noon on May 5.

FOUR MEDICAL SEMINARS WILL BE SPONSORED BY FMA AND THE AUXILIARY THROUGH Intrav during 1982. A Scandinavian Adventure (sponsored by the Auxiliary) for 15 days will leave from Miami, Tampa and Jacksonville July 5, returning on July 19, 1982. It will feature deluxe visits to Stockholm, Helsinki, Oslo and Copenhagen and a cruise on the Swedish Archipelago. The Alpine Adventure (sponsored by FMA) will be a deluxe two-week trip to Switzerland and the Italian Lake Region. It will have departures from Jacksonville, Tampa and Miami on July 18 and will return July 31, 1982. The European Capitals Adventure (sponsored by the Auxiliary) leaves from Miami, Tampa and Jacksonville on September 8, and returns September 21, 1982. It will include two weeks in the world's most popular cities, Paris, Rome and London. An exciting 15-day Orient holiday package (sponsored by FMA) will leave from the same Florida cities on September 30, and return October 14, 1982. The Far East Adventure will feature stops in Tokyo, Kyoto, Singapore and Hong Kong. For additional information regarding any of these tours, contact the Management Services Department, FMA Headquarters Office.

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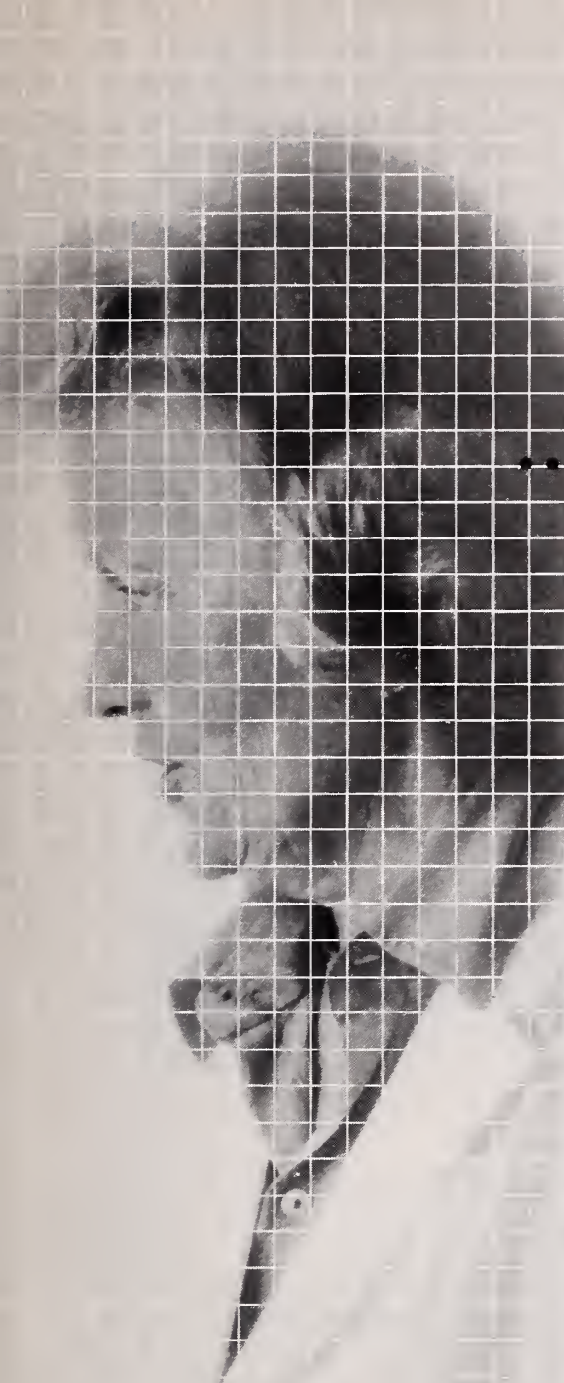
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**THE PATIENT THINKS
HE HAS HEART TROUBLE...**





...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

VALIUM[®] ^{IV}

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

BECAUSE YOU'RE CONVINCED
THE PATIENT NEEDS IT



Please see summary of product information on the following page.

VALIUM® (diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Special Health Care Financing Issue

The March issue of the *Journal of the Florida Medical Association* is devoted to Health Care Financing. The papers published this month were presented at the 1982 Florida Medical Association Leadership Conference January 30-31. Charles P. Hayes, Jr., M.D., Chairman of FMA's Council on Health Care Financing, has served as Guest Editor of this issue.

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The cover depicts the various aspects involved in any study of health care financing.

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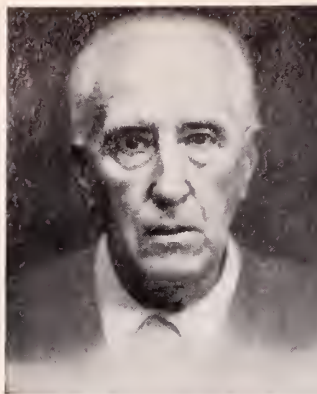
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FMA Committee on Impaired Physicians



President's Page

The Florida Medical Association and Health Care Financing

On January 30-31, 1982, the Florida Medical Association's Annual Leadership Conference was held in Lake Buena Vista. The usual format of the conference was changed rather dramatically with the entire program devoted to a single topic, "Health Care Financing."

This single topic was selected for the conference because of the great importance of this subject to all Americans. It was felt that the leadership of the state and county medical organizations should have an opportunity to review in depth the problems relative to the financing of health care. It was also agreed that the various aspects of health care financing should be presented by individuals who are nationally recognized as being experts in their area of interest. These individuals were to be given complete personal freedom in preparing their remarks. There was to be no effort to spare the feelings of the doctors who attended the meeting. The speakers were asked to "tell it like it is."

With these concepts as a basic working philosophy, contacts were made with individuals throughout the United States. Much assistance in helping to find experts in the field was gained by consultation with the American Medical Association, particularly Dr. James H. Sammons, Mr. Joseph D. Miller and Mr. Wayne Bradley. Discussion concerning prospective speakers was also carried out with the officers and members of the board of governors of the FMA as well as others. Dr. Charles P. Hayes, Jr., chairman of the FMA Council on Health Care Financing was particularly helpful. The entire program was superbly coordinated by Mr. Donald C. Jones, FMA Executive Director, with the able assistance of Mr. Philip H. Gilbert, FMA Director of Medical Economics.

As the program began to develop, it became obvious that there was going to be a wealth of talent involved.

Accordingly it was decided that a special issue of the *Journal of the Florida Medical Association* should be devoted to publishing the papers of the speakers at the conference. Dr. Hayes agreed to be Guest Editor for the special issue. Quick and effective cooperation was obtained from Dr. Daniel B. Nunn, Editor of the *JFMA* and Mr. Edward D. Hagan, Executive Editor. By their efforts we were able to have the special issue with all of these papers published in this, the March 1982 issue of the *JFMA*.

When one considers that the delay between receipt of a manuscript and publication in a medical journal is frequently more than a year, the magnitude of the efforts of Dr. Nunn, Mr. Hagan and their staff can be understood to some small degree. It should also be pointed out that all of the speakers were extremely supportive of this effort and submitted their papers in time for publication. They cannot be thanked enough for their cooperative attitude.

The program itself turned out to be quite successful. Many favorable comments were received concerning the quality of the speakers and their presentations. It is unfortunate that all members of the FMA were not present but those in attendance had a most instructive and enlightening day and a half conference. The reader is encouraged to study carefully the papers on health care financing in this issue of the *JFMA*. They point the way to at least some of the activities and challenges facing medicine and all of the citizens of this great country in the financing of health care during the 1980's and beyond.

Several broad principles were presented by the speakers. A brief listing of the major concepts developed at the conference is as follows:

1. The decade of the 1980's and 1990's will make a major impact on the delivery of health services.

Many changes are anticipated. The entire subject is extremely complex.

2. Doctors of medicine are still highly regarded by the people of the United States. Doctors and clergymen are the two most respected professions and usually alternate between first and second place on various polls. Other ranked professions are far below the two leaders.
3. In general the public likes the quality of medical care but is becoming concerned about the cost of medical care although they do not believe that the doctors are responsible for the increase in cost.
4. There is a great desire by most people to retain a close and personal doctor-patient relationship.
5. The problem of increasing cost in health care is a broad-based social problem involving all parts of society, not just doctors and hospitals.
6. Doctors must be heavily involved in developing solutions to the problems relative to the increasing costs of health care.
7. Doctors must be willing to provide effective peer review and work actively to remove the small number of incompetent and venal physicians who are in practice.

8. Most thoughtful consumers and leaders from business, industry, labor, health insurance and hospitals want to work with doctors in helping to solve the problem of increasing health care costs.

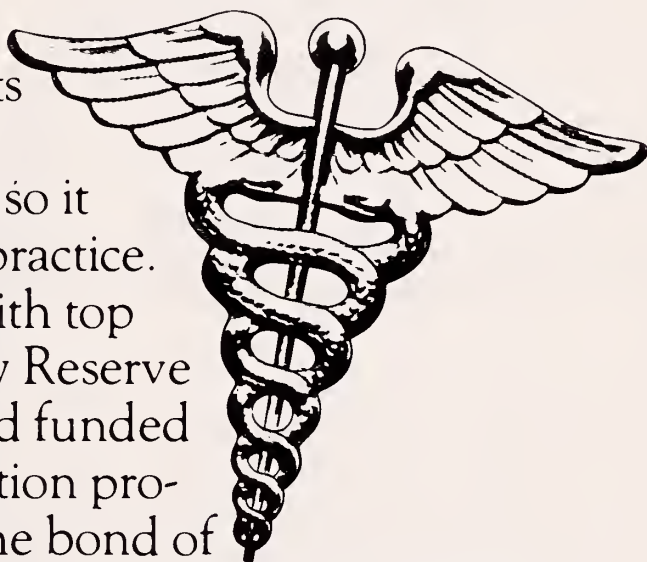
9. There is going to be a change in financial rewards for doctors as the increased number of doctors enter practice in the next decade. This may well result in reduction of the incomes of most doctors but the compensation for this will be in the improvement of lifestyle with a better opportunity for doctors to be more involved with their families and communities.

The conference has made it abundantly clear that it is essential for doctors to become an active part of the groups at the local level which are beginning to make decisions as to the way health care will be delivered in the future. Local community leaders in most instances want doctors to be active participants. Doctors have the responsibility to protect the quality of care and make certain that quality is never compromised in the rush to save dollars.

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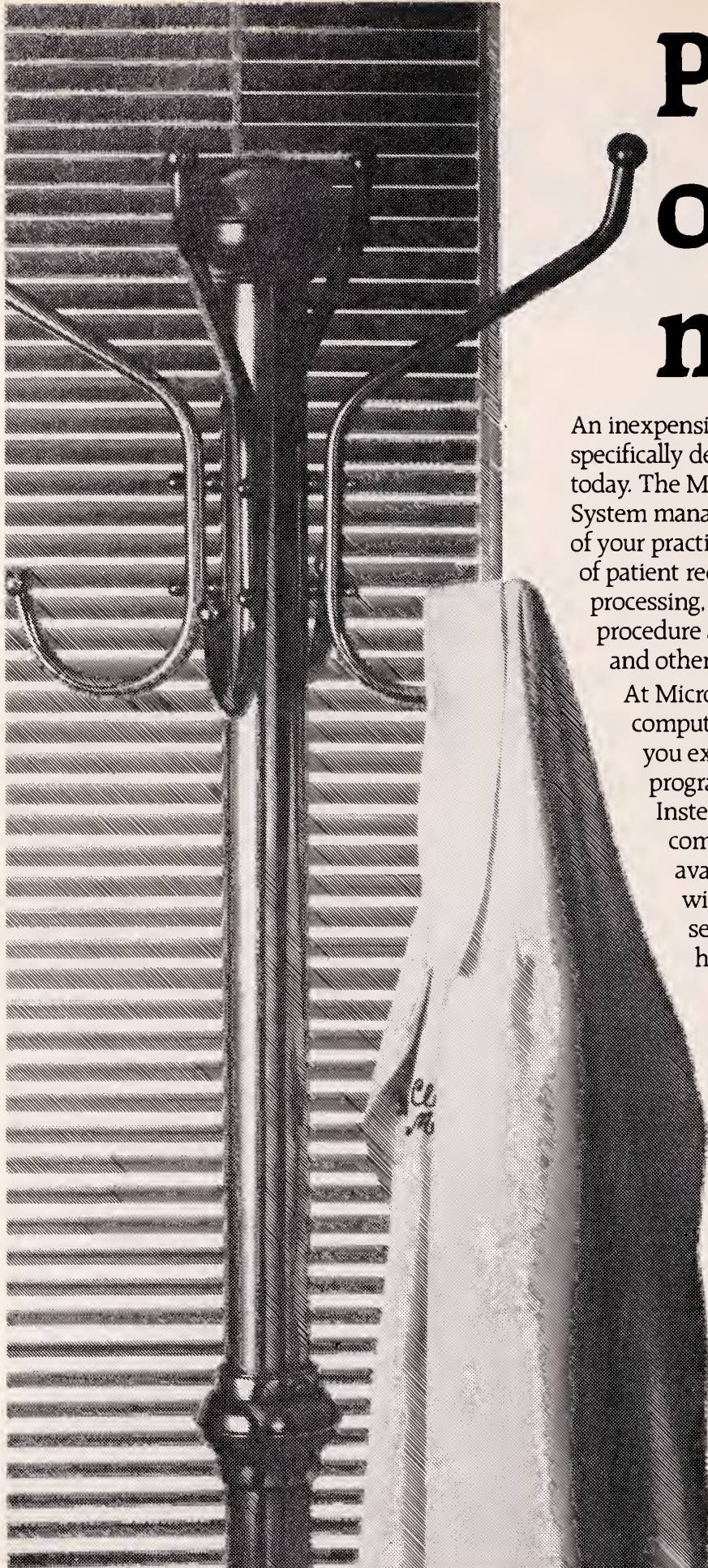
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Professional Liability Legal Update

Medical Malpractice Claims Causes and Prevention

Annually, we report in the *Journal of the Florida Medical Association* the ten leading causes of medical malpractice claims which have been reported from the FMA's sponsored plan for the years 1963 through the year just completed. This report updates the data through December 31, 1981.

Our series of closed claims in Florida is now 11,905, which represent losses paid in excess of \$176 million. The claims have been divided into 21 categories, and the 10 most frequent and the 10 most severe are as follows:

Ten Leading Malpractice Causes (FMA's Sponsored Plans 1963-1981)

Frequency

1. Improper diagnosis (not involving surgery)
2. Technical surgical error
3. Adverse reaction to drugs
4. Improper treatment of fractures
5. Improper anesthesiology
6. Injury to a child in childbirth
7. Infection in surgical site
8. Foreign body left in patient during surgery
9. Injury from falls (during examination or while under doctor's care)
10. Employee error

Severity

1. Injury to child in childbirth
2. Injury to mother in childbirth
3. Improper anesthesiology
4. Abandonment
5. Improper diagnosis (not involving surgery)
6. Employee error
7. Technical surgical error
8. Adverse reaction to drugs

9. Infection in surgical site
10. Assault (generally, operating without prior permission)

Frequency

There were no changes noted during the year among the first five causes of malpractice claims as to frequency. Injury to a child at childbirth, which was number 8 in 1979, and number 7 in 1980, is now number 6 at the end of 1981. This is further significant in that injury to a child in childbirth now ranks number 1, having been number 3 last year, as to the severity of the claims paid.

Severity

The trend as reported for the past 3 years as to awards in cases resulting from childbirth continues. Injury to a child in childbirth, which was number 3 last year, is now number 1 as to severity, with injury to a mother in childbirth at number 2. Improper anesthesiology is now number 3—4 years ago these three did not appear in the top 10 as to severity.

Abandonment, which now ranks number 4 as to severity, has never before placed in the top 10. Similarly, employee error, which was formerly number 8 as to severity, is now number 6. Technical surgical error, adverse reaction to drugs, infection in surgical site, and assault remain in relative position, those having been displaced by abandonment and employee error. Foreign bodies left in patients during surgery, which ranked number 6 last year, is no longer in the top 10 as to severity.

Comment

These changes are monitored closely to determine changes in the medical malpractice picture in Florida. It is obvious from a review of the order of these claims that most are preventable.

Prepared and submitted by James W. Walker, M.D., President, Professional Insurance Management Co. (PIMCO), Jacksonville, Florida.

There continues to be a need for obstetricians, pediatricians, and anesthesiologists to document thoroughly those procedures in which they become involved. During 1981 pediatricians, radiologists, neurologists, and emergency physicians experienced an increase in their premium classification structure as a result of losses.

The Professional Insurance Management Company (PIMCO), on behalf of the Florida Physicians' Insurance

Reciprocal, will continue its medical malpractice prevention program throughout Florida during 1982. To date, some 6,600 Florida physicians have attended these three-hour seminars. Physician awareness as to the causes and prevention of medical malpractice claims will ultimately affect the premiums each of us must pay for professional liability insurance.



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\$1.50 REBATE DIRECT TO YOUR PATIENTS ON EVERY PRESCRIPTION OF 100. REFILLS INCLUDED.

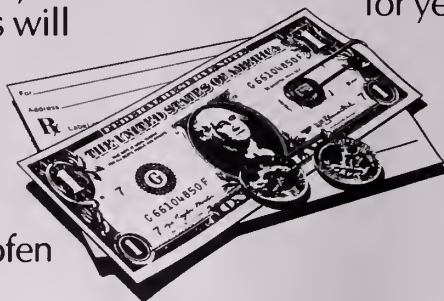
One dollar fifty cents returned for every Rebate Coupon your patients mail in.

Every bottle of 100 tablets of RUFEN 400 mg has a Rebate Coupon attached, with full instructions for redemption.

It has already been determined, through public opinion research, that most arthritic patients will appreciate direct rebate savings as much as they appreciate the results of ibuprofen therapy.

AND RUFEN IS PRICED LOWER TO BEGIN WITH.

Boots has already priced RUFEN lower to the wholesaler and the retailer. And if these savings are passed along, as they should be, your patient will receive the benefit of this lower price. Add these savings to the rebate, and your patients receive substantial relief from the costs of a medication many of them may take for years.



RUFEN IS NOT A GENERIC. BOOTS IBUPROFEN IS THE ORIGINAL.

And if you wish, RUFEN may be substituted for Motrin[®], because it is bio-equivalent.*

Original research by The Boots Company Ltd., of Nottingham, England, developed ibuprofen.

And though we introduced it ourselves elsewhere around the world, we licensed ibuprofen for sale in the United States.

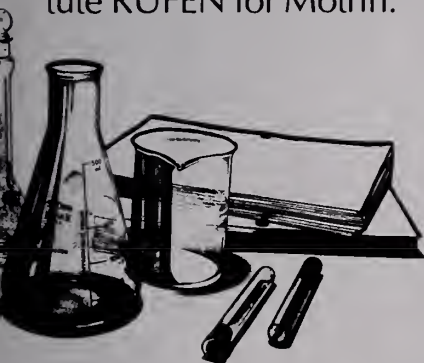
ARTHRITIC PATIENTS IBUPROFEN THERAPY.

You first came to know it as Motrin (ibuprofen), manufactured by Upjohn.

Now, as we have established facilities in America, we hope you'll come to know Boots brand name for ibuprofen as RUFEN.

BIOEQUIVALENCY? OF COURSE.*

That's why you may substitute RUFEN for Motrin.



ALSO: A BOOTS CONTRIBUTION TO ARTHRITIS RESEARCH WITH EVERY REBATE.†

A 25¢ contribution per rebate is built directly into the RUFEN program. And with thousands of prescriptions anticipated for RUFEN 400 mg each year, the annual potential for arthritis research is enormous.



Rufen®
(ibuprofen)

*Data on file.

†Contributions made to: International League Against Rheumatism.

WHEN YOU'RE WRITING YOUR NEXT PRESCRIPTION FOR IBUPROFEN, PLEASE REMEMBER:

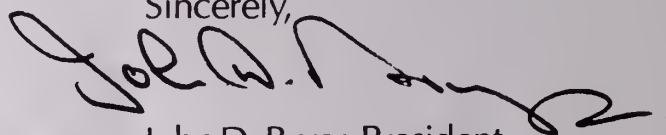
- RUFEN®** OFFERS A \$1.50 REBATE DIRECT TO YOUR PATIENTS ON EVERY BOTTLE OF 100 TABLETS OF RUFEN 400 MG.
- RUFEN** COSTS YOUR PATIENTS LESS TO BEGIN WITH.
- RUFEN** CONTRIBUTES 25¢ PER REBATE TO ARTHRITIS RESEARCH.
- RUFEN** IS NOT A GENERIC... BOOTS IBUPROFEN IS THE ORIGINAL.
- RUFEN** (IBUPROFEN) IS BIOEQUIVALENT TO MOTRIN® (IBUPROFEN).*

I hope we've given you several good reasons to re-member RUFEN the next time you prescribe ibuprofen.

If we haven't, or if you'd like to know more about Boots Pharmaceuticals or this program, please don't hesitate to drop me a line. Or call us directly at our toll-free number: (800) 551-8119. Louisiana residents, call (800) 282-8671.

To ensure that your patients receive the benefits of the Rufen program, *be sure to specify "D.A.W.," "No Sub," or "Medically Necessary,"* as required by the laws of your state.

Sincerely,



John D. Bryer, President
Boots Pharmaceuticals, Inc.



Boots Pharmaceuticals, Inc.
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Pioneers in medicine for the family

RUFEN® (ibuprofen/Boots)

(For full prescribing information, see package brochure.)

RUFEN® Tablets
(ibuprofen)

INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS

Incidence greater than 1%

Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4% to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see PRECAUTIONS). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecostasia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106

Guest Editor's Introduction

Health Care Financing Issues

Charles P. Hayes, Jr., M.D.

Those members of the Florida Medical Association who were unable to attend the 1982 FMA Leadership Conference missed an informative and stimulating program that was assembled by FMA President Sanford A. Mullen, M.D. Fortunately, the speakers have provided manuscripts that comprise this Special Issue of *The Journal*, so that the membership has the opportunity to read what was presented at the Conference, which was devoted entirely to health care financing.

Eli Ginzberg, Ph.D., a nationally renowned medical economist leads off this special section with an overview of the health care cost issues, as he did at the Conference. He discusses his views of the factors leading to rising health care costs and gives us insight into the changes in the health care system that he expects to take place in the near future.

The role of government, with emphasis on the Reagan Administration's proposed new division of responsibilities between the federal and state levels was discussed by the under Secretary of Health, Dr. Edward Brandt; FMA past president and Florida House of Representatives Majority Leader Richard S. Hodes, M.D.; and Gary Clarke from their respective perspectives. Dr. James Sammons, Executive Vice President of the AMA and I, as Chairman of the FMA Council on Health Care Financing reviewed the activities of organized medicine in dealing with the problems of medical economics.

I would urge you to read carefully the articles prepared by the public representatives who so effectively described the attitudes of the business and public sectors. Mr. Robert Carpenter of Republic Steel Corp., Miss Bess Myerson, a nationally known consumer advocate; and Mr. Roy Pfautch, a leading pollster, provided some insights into the public views of their expectations of them in dealing with this difficult problem. Mr. Steve Doiron describes the HMO and IPA

initiatives in great detail. Drs. Todd and Astler very ably present the impact of rapidly escalating medical malpractice costs.

Although many of the points made at the leadership conference this year were discussed in Dr. Mullen's President's Page, a few seem important enough to restate here. The first is that all sectors of society perceive the rising costs of care to be the major problem with our present health care system. Secondly, although physician fees in general may not be the major contributor, physicians are viewed as key managers of health care expenditures. More and more we see others from the business and public sectors coming to recognize the need for participating in these solutions, a healthy sign. Therefore, it is essential that physicians become involved in molding the solutions that others in both government and the private sector are developing. The final product will have a tremendous impact upon the manner in which health care is delivered in the future, a matter of vital interest to both patients and physicians.



The Changing Economic Framework For U.S. Health Care In the 1980s

Eli Ginzberg, Ph.D.

Alpha Omega Alpha

In an address to the Alpha Omega Alpha chapter of New York University in the spring of 1977 that was later published in the *Annals of Internal Medicine*, I answered the question that was raised by the title "How Much Will American Medicine Change in the 1980s?" with a brief "not much." Today, I would reformulate my earlier forecast and say "quite a bit."

Then, as now, I have been impressed that most Americans when queried in opinion polls provide positive answers as to whether they are satisfied with the health care they receive. If most consumers find "the market" providing them with what they want and can pay for, a major source for change in the system is not present or operative.

The year 1977 was the first year of the Carter Administration and the newly elected President, while sending out mixed signals, nevertheless was in the mainstream of the liberal Democratic Administrations at least as far as domestic programs were concerned. In campaigning for the presidency he had moved close to supporting the AFL-CIO position on National Health Insurance (NHI). I might add parenthetically that for the one and only time in my life I wrote a small book specifically to influence a President. My *Limits of Health Reform: The Search for Realism*, Basic Books, 1977, was written for the explicit purpose of alerting the President that NHI was not the preferred next move in national health policy. While I have reason to know that he read the book, I am under no illusion that my logic persuaded him to back off. The better way to explain what happened is to note that the President's staff was never able to formulate a viable NHI plan that could be fitted into the

budgetary constraints. One of the key elements in my 1977 forecast was my skepticism that the country, after 66 years of non-action since NHI was first introduced into the Bull Moose campaign of Theodore Roosevelt in 1912, was going to be enacted in the near future.

Increase in Physician Manpower

Although a long-term student of health manpower and more particularly the changing trends in physician manpower, I did not place as much weight as I do today on the 30 per cent increase in physicians per capita within 12 years (1978-90) that looms ahead.

No one resident in New York State in 1977 was oblivious to the fact that many hospitals were in financial trouble because, among other reasons, of the tight reimbursement practices that the State had put into effect as early as 1969 and which had been tightened in the intervening period. But I did not anticipate the substantial shrinkage in the hospital plant that looms ahead as a result of the combined influences of reduced reimbursements, cash flow difficulties, the high cost of borrowing, and competition from hospital chains as well as from physicians.

Nor did I foresee in 1977 the much intensified financial pressures that would confront the federal and state governments which would lead them to seek budgetary relief by cutting back on all controllable expenditures, including those for health.

Finally, I did not anticipate the strength of the anti-populist sentiment that would elect Ronald Reagan and lead him to cut back on entitlement programs including Medicare and Medicaid. For all of these reasons, I now want to shift my forecast from "not much" to "quite a lot."

Public Satisfaction

As of the beginning of 1982 the American public, at least in my view, is still satisfied by and large with his health care system, NHI is not a near term or even middle term threat. But it would be an error to assume that the system will not change much during the rest of this

The Author

ELI GINZBERG, Ph.D.

Dr. Ginzberg is Hepburn Professor Emeritus of Economics and Director, Conservation of Human Resources, Columbia University, New York City.

decade. My sense is that it will change quite a lot in part for the reasons already indicated: the increasing supply of physicians; the mounting financial pressures on hospitals; and the budgetary constraints on all levels of government which today contribute 42 cents of every health dollar.

Let me spell out some of the implications of the foregoing and call attention to a few additional forces that are likely to impact the system in the years ahead.

A steep increase in the rate of physicians per capita suggests the following: the *relative* earnings of physicians is almost certainly going to decline and many of the new entrants into the profession are going to encounter difficulties in building up a successful practice. The earnings of many older physicians will fall behind the inflation rate. The potential "oversupply" will make it easier for many new health delivery systems that depend on salaried physicians to get going and for more of the new delivery systems to survive. I anticipate a steady, if not spectacular, increase in Health Maintenance Organizations (HMOs), but also the transformation of some hospitals into comprehensive health care agencies providing all sorts of care in addition to in-patient treatments. Of course there will also be new types of practice arrangements among physicians which are likely to result among other developments in the reemergence of house calls. With more physicians in search of paying patients, it is inevitable that the tensions between physicians and other health providers including nurse practitioners, physician assistants, and others from within and outside of allopathic medicine will intensify both in the market place and in the halls of the legislature.

As already suggested above, I expect to see considerable "diversification" of services not by all but by the more aggressive hospitals as they struggle to maintain and increase their revenues. No matter what hospitals do, I expect their number to decline substantially through closure, merger, affiliations. Moreover, I think that they will be under heightened pressure to compete on price as well as quality both among themselves and with many physicians who will increasingly seek to protect their income by reducing their in-patient admissions. Ambulatory surgery will grow; referrals will be reduced; patient stays will be shortened, all of which speak to the mounting pressures that hospitals will be under to remain financially viable.

Pressure on Providers

The growing efforts of the federal government, followed by state and local governments, the Blues and commercial insurance to contain their outlays will put increasing pressure on providers, particularly physicians and hospitals, to do more for less and in the event that such proves to be impossible to do less. Inglehardt's

piece in *The New England Journal of Medicine* for late November provides a listing of the several actions that the federal government has taken, or will shortly undertake, to contain its outlays for health.

I see medical technology continuing to advance as a result of which per diem hospital costs will continue to rise. The demographic trends contain a warning—more older people, especially those in the age group above 75 use a lot of health services. The domain of health care is being steadily broadened to include weight control clinics, more cosmetic surgery, spas, and much more. In short, all of the foregoing point to cost increases, not to cost containment.

Let me conclude by sketching the changes in health care over the rest of this decade, that lead me to conclude that the system will change "quite a lot."

The predominant fee-for-service solo or small group practice arrangements that dominate today will be confronted by a plethora of new types of delivery systems.

Many smaller hospitals will disappear; hospital clinics will grow; and some hospitals will be transformed into comprehensive community-like health care agencies. This development will impact physicians in two respects: increase the struggle over hospital privileges and add another competitor to the ambulatory care market.

There will be continuing and even accelerating efforts by all third-party payors to constrain their outlays which will lead to more price competition among providers and more regulation of physician fees not only in the case of Medicare and Medicaid beneficiaries but also for all patients who are covered by third-party payors.

More regulations will be insisted upon by third-party payors but carried out in considerable measure by physicians aimed at controlling health care outlays both in the hospital and outside through norms involving procedures, length of treatment, reimbursement.

Conclusion

As noted above I see much intensified competition, including price competition among health care providers but I am skeptical that the Congress will pass any of the pro-competition proposals now in the legislative mill. Further, although third-party payors will make increasing efforts to contain costs, I expect the proportion of health care costs as a percentage of GNP to increase from 9.4 per cent to 11 per cent or more. In the pulling and hauling among the various interest groups there is a serious danger that many of the poor and the near poor will no longer have a net under them. Government will seek to unload part of its responsibilities for the poor onto the

private sector. Either the private sector picks it up or the citizenry will have to pay more taxes so that government will continue to discharge this responsibility. The poor of the country are not going to be denied access to essential health care services.

Finally, most of the action in the 1980s will involve not the poor but the paying patient. The key issues will involve how much of the total costs will the federal, state and local governments continue to cover; how much will insurance reimburse; how much will the patient pay out

of pocket. When money runs out, what services will be cut back and eliminated? And how will the available dollars be divided between the two principal providers—physicians and hospitals? The 1980s should prove to be interesting times.

- Dr. Ginzberg, Director of Conservation of Human Resources, Columbia University Uris Hall, New York, NY 10027.

Government's Role in Health Care Financing and Delivery

Edward N. Brandt, Jr., M.D.

Very few medical students a generation ago would have given much thought to taking a course in cost accounting, public tax policy, or even introductory economics. But today's practicing physicians — and their young colleagues in medical school — are bombarded every day with information about the cost of medical care. Practitioners do not have to take courses; they are already immersed in the statistics and the issues of health care financing.

This preoccupation with financing is not particularly new, but there is an aura of urgency about it today that was not so apparent just a few years ago. Until recently, the medical community had expressed the strong feeling that somehow we could handle this problem by ourselves. We could get control of it; we would respond to the public's genuine concern about the rising costs of medical and health care.

Since then we have come to understand that the heart of the cost issue — inflation — cannot be controlled by any one sector or activity in society. The entire nation has to be galvanized to move against inflation on all fronts, in all sectors, and among all activities.

That was a major element of the campaign platform of Candidate Reagan. It became the first domestic priority for President Reagan.

Inflation is theft — theft of resources, of initiative, of past victories, and of future hopes. Those of us who work in the vineyards of medicine know inflation to be our worst imagined blight. And it exacts a very high price.

Inflation

According to the Bureau of Labor Statistics, the Consumer Price Index for all items in the economy rose 13.3 per cent in 1979, and 12.4 per cent in 1980. As of the

end of 1981, however, after a year of all-out effort to fight inflation, the CPI rose only 8.9 per cent. The trend line for the economy in general was turned around. But it was a different story for the medical care component within the overall CPI.

In 1979, the medical care price index was up by 10.1 per cent, and in 1980, it was up by 10.0 per cent. But in 1981, it rose by 12.5 per cent. In other words, the trend for cost controls in medical care was the reverse of the trend for nearly every other aspect of the consumer economy. The prices of fuel oil and used cars also went up.

In 1980, Americans spent a total of \$218 billion on personal health care—physicians' fees, drugs, dental care, hospital room charges, private health insurance, and so on. When all the figures come in for 1981, we expect the total for personal health care expenditures will rise to about \$250 billion. Of that difference from one December to the next, inflation by itself was responsible for some \$25 billion.

Last year's medical care price index of 12.5 per cent was a record high on two counts:

- It was the biggest year-end rise over a prior year.
- It represented the highest dollar figure for inflation in medical care costs.

That has to be a very sobering piece of news for every one of us. That extra expenditure of \$25 billion last year came right off the top, yielding no additional health benefits for our people:

- Inflation provides no additional relief from pain.
- Inflation does not reduce the risk of infection.
- Inflation contributes nothing to the reduction of infant mortality or maternal morbidity.

Nevertheless, the American people paid that extra inflation cost for the health care they received last year.

But the medical community paid it also. Physicians, hospital administrators, and others involved in delivering quality health and medical care also paid that extra tribute to inflation when they bought equipment, space, and energy; when they hired staff; or when they pursued a program of continuing education. Medical practice has been as much a victim of inflation as any other profession or activity in our society.

The Author

EDWARD N. BRANDT, JR., M.D.

Dr. Brandt, Former Chairman of the American Medical Association Section on Medical Schools, currently serves as Assistant Secretary for Health, U.S. Department of Health and Human Services, Washington, D.C.

A Key Stimulant

As you are aware, President Reagan saw the extraordinary growth in the Federal budget as a key stimulant to the inflation spiral. Through this continuing dialogue with the Congress and the American people over the past year, the President has reduced the role of the Federal Government in the American marketplace. The great power of the public purse had to be curbed somehow, and a 25-year trend brought under control.

The benchmark year was 1965. Medicare and Medicaid were enacted. The Regional Medical Programs for heart disease, cancer, and stroke were authorized. Programs were set up to build medical schools, provide scholarships and loans, and expand in many other dramatic ways the nation's supply of physicians, dentists, nurses, osteopaths, and other health professionals.

Federal spending for health care came to \$5 billion in 1965. In 1980 the Federal total came to \$71 billion — a 14-fold increase in one generation.

It is no small wonder, then, that the Federal bill for health and medical care became one of the first and most visible items for review by this Administration. Over the past year it has remained a high priority and I can assure the medical community of Florida that the Administration will continue to do what it can to reverse this trend of automatic annual increases in the Federal health budget.

We have been making some progress with the U.S. Public Health Service portion of the budget. For example, for Fiscal Year 1980 the PHS total appropriation was just over \$8 billion and rising. This Administration was able to cool that process down with a revised request for Fiscal Year 1981 of \$7.9 billion. During this current 1982 Fiscal Year, our appropriated level is \$7.4 billion. We anticipate that the final request by the President for FY83 will be in the neighborhood of \$7.2 billion.

The process of cooling down the Federal budget for health is very complex, since the fundamental questions to be answered are not really questions about dollars but are questions of health and medical service, for which a portion of each answer may be expressed in dollars. To me, that is a very important distinction and I would want to assure every provider of care in Florida that we have approached this highly complex issue of the budget as professionals in health and medical care, not as economists or as accountants.

Four Parallel Paths

Our approach moves along the following four parallel paths:

1. We are consolidating a number of service programs into block grants to the states and territories.

2. We are returning to the states and to the professions those activities that are properly theirs to control.

3. We are exploring ways to make free-market competition function in health and medical care as it does elsewhere in our economy.

4. We are focusing Federal resources on those activities which government does best.

President Reagan's proposal for health block grants was sent to the Congress in early March 1981 and emerged in August as part of the Omnibus Budget Reconciliation Act of 1981. The Act authorized more block grants than the President proposed and some programs that were to have been consolidated into the blocks were withdrawn and kept as categorical grant-in-aid programs. However, Congress accepted the block grant approach, lowered the level of funding (reversing a trend of more than two decades), and recognized the potential strength of the 50 states, six territories, and the District of Columbia to run these health programs in a manner best suited to the needs of their own residents. It was a strong, historic beginning.

Some editorial writers and others have been skeptical of the ability or the willingness of the states to assume control of the health blocks. I believe their opinion reflects a lack of knowledge about what the states already carry. Although buffeted by inflation as badly as any other sector of our society, state governments have maintained a consistent 13.5 per cent share of all health expenditures in our country over the past decade. Their outlays rose from \$10.1 billion in 1970 to \$33.3 billion in 1980, keeping pace with federal outlays and the contributions of the private sector.

But more than money is involved here. State health agencies have demonstrated the will to provide the health services that Americans need. In fact, state and local health agencies provided health services to 74 million people — one in every three Americans — in 1980. Almost 47 million of this number were screened for communicable and chronic disease and for maternal and child health status. The top five screening categories were venereal disease, vision screening, nutritional status, hearing, and hypertension.

Here in Florida during 1980, state and local health Agencies screened more than 600,000 residents for vision, more than 400,000 for nutrition and about the same number for hypertension. More than 300,000 were screened for hearing, tuberculosis and venereal disease. That adds up to well over 2 million screening procedures for the people of this state for just the top six screening services out of some two dozen categories—a very impressive record.

Maternal and Child Health

Of the 57 states, territories, and the District of Columbia, 53 have applied for the Maternal and Child Health Block and 54 have applied for the Alcohol, Drug

Abuse, and Mental Health Block (as of the end of 1981). We expect the remaining applications to come in as the fiscal year progresses; timing — not policy — is the problem for the ones to come in.

The block grants have few strings attached: the states need to inform their citizens about their plans, to have their books ready for a federal audit, to respect the rights of all citizens, and generally be accountable. These requirements take up a half-dozen pages in the *Federal Register*, compared to the more than 200 pages that governed the same programs when they were run as categorical grants-in-aid directly out of Washington.

There are, however, some programs that we feel ought to be passed on to the states and to the health professions themselves — with no strings attached at all.

We feel, for example, that the states and localities should have complete control over their own health planning. We tried to do this from Washington and it turned out to be quite costly without being very effective. I believe that Washington-based planning is an idea that has come—and gone. States and localities should have the flexibility to determine what kind of health planning can serve their own needs best, which organizations from the private sector and elsewhere in the public sector should take part, and how much authority they should have within their own jurisdictions.

I am a strong advocate of planning in health and medical care. I would encourage all state and local health agencies to do whatever is necessary to strengthen their planning capabilities. But I do not believe it is appropriate to enforce this point of view with the law or the power of the public purse out of Washington. To some people this may seem to be a radical shift in the direction of national health policy. But I am convinced that this is less a change in direction than it is a clarification and a reinforcement of the direction of policy down through our history. That direction has followed the deep and steady currents of American life flowing through our neighborhoods, our communities, towns and cities, and our states for more than 200 years. It is a direction first brilliantly explored for us in the *Federalist Papers* of Hamilton, Madison, and Jay.

Sometimes it is appropriate for the individual to assume primary responsibility for certain activities. The medical profession has the opportunity to do this in regard to the development and maintenance of professional standards. Good standards cannot be legislated or regulated or purchased; it has been futile and costly for the Federal Government to try. Hence, the Federal Government is withdrawing from the regulation of professional standards review organizations, or PSROs. That is the business of the profession itself.

As previously mentioned, the third road we intend to travel would lead to greater market competition in health

care. This is a difficult road to map out in advance; I believe that the experience of the next several years will tell us how accessible and how broad this highway should be. Nevertheless, we have made a bit of a beginning.

Over the past seven years the Federal Government has contributed \$350 million to help build the Health Maintenance Organization (HMO) movement. Private investors, including HMO members themselves, have contributed triple that amount over the same period of time. As a result we have about 250 HMOs in 38 states. We hope to remove the bindings of federal regulations and allow the HMO movement to respond with more flexibility to the needs of the marketplace.

In a related development, the Department of Health and Human Services has pulled together a display of the options for competition that may become part of national health policy in the years ahead. The nature of insurance coverage—how it is structured, how it is evaluated and bought, who pays the premiums, and how it is treated under current tax policy—all these are questions that need clearer answers or possibly new answers.

It is one thing to advocate “consumer choice” in the health marketplace, particularly in the area of insurance, but it is quite another thing to provide a range of clear, reasonable choices for the consumer to make. And when I use the term “consumer,” I use it to embrace not only the individual citizen and his or her family, but also the working person, the union or other employee association involved in collective bargaining, and employers who have a major stake in the processes of choice.

The government, by committing itself to move in the direction of stimulating market forces in the field of health and medical care, has taken the first important step. We will proceed to the next step and beyond with caution and deliberation. Eventually I believe we will develop a sense of momentum in this new and potentially liberating side of national health policy.

Constitutional Symmetry

Finally, I would return to the President's idea of restoring “the constitutional symmetry between the central Government and the States . . .” Neither side of the balance should be placed at risk. Strengthening the role of the States should not occur at the expense of the Federal Government. Our task, therefore, is to identify the strengths of the Federal Government, focus our resources and energies upon them, and thus secure for the American people the measure of protection and service they require from that source.

Clearly one of the great strengths of the Federal Government is its capacity for extensive biomedical and behavioral research. Complex, long-term basic research, for example, needs the continuity of federal funding and of scientific leadership. As of last October, the Public

Health Service—that is, the National Institutes of Health and the National Institute of Mental Health—had sponsored the research of 61 intramural and extramural scientists who had received the Nobel Prize. The total had been 58, but all three of this year's Nobel Laureates in Medicine—Drs. Roger Sperry, David Hubel, and Torsten Wiesel—raised that already impressive number to 61.

Although there are many strong claims on federal funds during this era of austerity, we intend to maintain our national research capabilities. The competition for dollars is very keen and, as I indicated earlier, the PHS budget is being cooled down. However, the funds for NIH for example, are still rising modestly, from a level of \$3.6 billion in Fiscal Year 1981 to a request in the neighborhood of \$3.7 billion for FY83. In this particular effort we have not only the invaluable advice and guidance of the research community, but also the good offices of the President of the United States.

Public Health Emergencies

The Federal Government is also the most appropriate and versatile instrument for meeting sudden public health emergencies, whether brought on by the hand of nature or of man. The five place names and headline phrases that follow will call to mind those times when the Federal Government was needed and it responded with care and dispatch:

- Mt. St. Helens
- Toxic Shock Syndrome
- Love Canal
- Dengue Fever
- Legionnaire's Disease

Let me add that, while the federal response in these and other instances is a critical response, it rarely is a solo response. The best job possible cannot be done without the assistance of public health professionals from state and local governments, private voluntary organizations, and professional associations who provide their Federal colleagues with the in-depth knowledge of local conditions vital to fast, effective public health action.

Finally, a fundamental tenet of the federal health enterprise is its commitment to the health and well-being of every American, regardless of income, race, age, sex, native language, or place of residence. Despite the

difficult economic problems ahead, we must be assured that the well-being of all our citizens—whoever and wherever they are—constitutes the foundation of national health policy and remains the ultimate responsibility of the Federal Government.

This commitment, which is so integral to our nation's social and political heritage, is especially precious to us at this time. We have witnessed since mid-December the human calamity that occurs in a country whose central authority has lost sight of the people whom it was meant to serve and turned its might upon them. We know that the average citizen can be destroyed either by government's power—or its lack of interest. Our great strength at the federal level is our commitment to remain intensely interested in the welfare of all our people and to work on their behalf. President Reagan recently recalled a line from James Madison that expresses this notion in the clearest of terms: "You must first enable the government to control the governed, and next oblige it to control itself." To the extent we do that is the extent to which we will prosper and be free.

A New Session of Congress

These, then, are the thoughts going through my mind during these weeks of preparation for working with a new Session of Congress, for strengthening our relations with state and local governments, and for doing those many other tasks that, together, constitute the new direction of national health policy. I am sure that our experiences over the past year will help us make the difficult choices in the years ahead, when we will need to maintain our vigilance for fiscal restraint.

No, this preoccupation with the economics of health care had never figured in my plans for a career in medicine. I had not thought it would become so important a part of my calling. But it is. We all share this interest in making health and medical care in this country affordable to both those who provide and those who receive that care. And knowing that you share these concerns with your government, in itself, a source of strength for government.

- Dr. Brandt, Dept. Health and Human Services, Washington, D.C. 20201.

Transfer of Health Programs (Block Grants)

Richard S. Hodes, M.D.

Benjamin Disraeli said, "The health of the people is really the foundation upon which all their happiness and all their powers as a state depend." This statement is more true today than ever; health care is a significant portion of our economy and government. In 1980, total national health expenditures were \$247.2 billion, representing 9.4% of the GNP (Gross National Product) of which forty-two per cent are public funds. One wonders about the ratio of health care to our GNP. Health services cannot be exported or imported. Does the significant health portion represent a decrease in goods production?

Our public sector has grown by leaps and bounds. In 1981, federal aid to states and localities reached approximately \$94.4 billion. This assistance flowed out of the national treasury in nearly 500 different programs.

The Omnibus Budget

The Omnibus Budget Reconciliation Act of 1981, passed by Congress in July, merged some federal categorical programs into nine block grants, made changes in more than 250 federal programs, and set authorized spending levels below prior levels. These authorized levels represent the maximum amount that Congress may appropriate for specific federal programs in any given year and in total, resulted in the largest reduction in federal spending in the nation's history.

Block grant legislation may become a major turning point in the course of state/federal relations. State legislatures are expanding their role in the oversight of all federal grant monies. Initially, state legislative involvement with block grants was limited. Most legislatures were not in session when the federal government offered the grants to the states on October 1. Florida was one of seven states in which the legislatures created special

committees to deal with block grants. Most governors took charge of the grants, utilizing the opportunity of no sessions and the surrounding confusion. This has set the stage for quite a battle for control between the legislatures and governors.

Inconvenient Timing

Despite the inconvenient timing for state legislatures, most states have opted for state administration of block grants. Two of the nine blocks—Social Services and Low Energy Assistance—were automatically transferred to state governments on October 1. This eliminated the need for acceptance by the state. Two other programs, Primary Care and Education, will not be made available until 1983.

States can elect to participate in 5 optional block grants. To date the scorecard is as follows:

Alcohol, Drug Abuse & Mental Health	49 states
Community Services	38 states
Maternal & Child Health Services	48 states
Preventive Health & Health Services	48 states

The fifth block grant, Community Development/Small Cities, was expected to be available in late February, 1982. Florida has accepted all available block grants except Community Services. This grant has been recommended by the Governor to the Legislature for acceptance. This decision will be made during the current legislative session.

Following is a brief summary of health-related block grants:

I. Preventive Health and Health Services Block Grants:

Consolidated Programs: Emergency Medical Services
Health Incentive Grants
Hypertension Control
Rodent Control
Community & School Based
Flouridation

The Author

RICHARD S. HODES, M.D.

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Health Education/Risk Reduction
Home Health
Rape Crisis Centers

These programs are currently administered by the Department of Health and Rehabilitative Services, except for several emergency medical services grants and the home health grants. The rape crisis centers are a new responsibility for the public health program.

Funds for Florida total \$2.7 million, a 36% decrease. They represent 3% of the national appropriation. Several block grants have transfer allowances, which permit a state to "transfer" up to a certain amount to another block grant. The Preventive Health and Health Services block grant has a transfer allowance of 7%. There are no state matching requirements.

The required provisions are:

- States cannot use more than 10% of funds for administration.
- States must expend 75% of funds provided to the state in 1981 on hypertension programs, in 1982. This percentage decreases to 60% of such amount by 1984.
- After the first year, the Legislature must hold public hearings on proposed use and distribution funds.
- The governor must submit an intended use plan, which must be made public.
- Annual fiscal and audit reports, as well as the establishment of fiscal and accounting procedures, are mandated.
- States may not use funds to provide inpatient services, to make cash payments to intended recipients of health services, or to purchase or improve land or buildings.

This block suffered the largest cuts of all the grants.

II. Maternal and Child Health Services

Consolidated Programs: Title V of the Social Security Act

Maternal and Child Health and
Crippled Children's Services

Supplemental Security Income
for Disabled Children

Lead-Based Paint Poisoning
Prevention

Sudden Infant Death Syndrome
Hemophilia Treatment Centers
Adolescent Pregnancy
Genetic Diseases Program

Funds total \$9.7 million, a 21% decrease. They represent 3% of the national appropriation. There is no transfer allowance in this grant. Matching requirements are three state dollars for every four federal dollars.

The required state provisions are:

- States must use "substantial" portions of funds to provide health services to mothers and children, with special consideration given to continuation of special projects funded under Title V.
- States must use a reasonable portion of funds to reduce infant mortality, reduce preventable diseases and handicap conditions, increase maternity care, increase child immunization, and increase assessments and services to low income children.

III. Primary Care

This block grant contains no consolidation. It allows the state to administer the Community Health Center Program in 1983 and thereafter. It remains categorical with almost no state flexibility. All funds must be passed through to community health centers. The program is a direct federal/local grant. Funds appropriated will be reduced by 14.3%. The Governor has made no recommendation to the Legislature for acceptance of the Primary Care Grant.

IV. Alcohol, Drug Abuse and Mental Health Services

Consolidated Programs: Community Mental Health
Centers Act

Mental Health Systems Act
Sections 301, 312-
Comprehensive Alcohol
Abuse and Alcoholism Prev-
ention

Treatment and Rehabilitation
Act — 1970

Funds appropriated will be reduced by 28%. We received 5.26% of the state share in funds. Transfer of funds may occur up to 7%. DHRS currently administers only the drug abuse staff formula grants and the alcoholism state formula grants. The mental health services grants and the drug abuse — alcoholism project grants are a direct federal/local relationship.

Grant Allotments

Block grant allotments are as follows:

	Share	Amount (millions)	Comparison/ Last Year
Social Services	4.27	\$102.5	Decrease 12
Low Income			
Home Energy	1.36	19.0	Decrease 20
Community Services	2.95	6.6	Decrease 38
Alcohol, Drug Abuse	5.26	25.5	Decrease 28
Primary Care	Possible Decrease by 13%		
Maternal & Child Health	2.98	9.7	Decrease 21
Preventive Health	3.00	2.9	Decrease 36

There is a serious problem with these block grants. Flexibility has not been given to states for administration. In the face of severe budget cuts, dislocation has occurred for many. Had the states been utilized to target funds and work through individual internal politics, the plan might have worked.

The blocks are narrowly based, containing too low a percentage of appropriated dollars. This problem, combined with the tax cuts and defense expenditures resulted in a more serious federal deficit and a continued need to borrow money for operation. We are now in the throes of an economic recession, deeper and longer than anticipated. The tax cut theory should be stimulating to greater productivity and increased revenues, but because of the time lag between cuts and increased productivity, maintaining any public acceptance of the new economics is impossible.

State of the Union Address

The President, in his State of the Union Address, addressed a new issue: transfer of programs. He proposes the Federal Government take responsibility for all Medicaid. The states would fund Aid to Dependent Children (AFDC) and food stamps. Forty-four other federal programs would be funded through an excise tax trust fund of some \$28 billion, collected annually over the next four years. After that, President Reagan envisions that states will begin to collect excise taxes and the Federal Government will step away from those programs.

Nationally, the difference in transfer of programs leaves the states with \$3 billion dollars less. In Florida, the difference would mean a deficit of \$400 million. We have a \$500 million food stamp program alone. The biggest gainer state is New York, where the Medicaid program is more substantial.

In the long run, however, the changes in funding would benefit Florida and make some of the programs more effective. We would have the ability to make the food stamp program more efficient. Florida is the third highest per capita contributor to federal excise taxes and since collection of these taxes is returned to the states, no one will fare better than us.

Tough Years Ahead

Fiscally, most states are facing tough years. States with the most serious budget problems include Washington, Minnesota, Ohio, Oregon, Michigan, Kentucky,

Massachusetts, and California. Most regions of the country are affected, including the Sunbelt.

Seven states anticipate large budget balances, i.e., at least 10% of annual spending. All of them are west of the Mississippi and most have booming oil, natural gas, and/or coal industries.

The cutbacks of federal aid are not the primary cause of state fiscal distress, but they exacerbate it. Those cutbacks could hardly have come at a worse time in view of the anemic condition of state budgets. Florida has a current revenue shortfall of \$178 million, and must deal with federal cutbacks as well.

Within the past year, 37 states and the District of Columbia have increased existing taxes or imposed at least one new one.

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Within the past year, 37 states and the District of Columbia have increased existing taxes or imposed at least one new one. These boosts amount to \$3.1 billion, the largest increase in a decade. This was "before" block grants were in place; where can we go from there?

Recently Sen. Howard Baker of Tennessee suggested that of the existing federal programs in operation: one third should be operated *only* by the federal government, one-third should be operated *only* by the states; and the remaining one third should be operated as state/federal categorical programs. He alluded to the potential turnback of excise tax areas which President Reagan has now clarified in his proposal. Creative financing can occur but the states must be careful in their acceptance. Great disparities among states will make a difference in national policy and state effects.

Health Care Important Here

Florida has a large elderly population—17% compared to a national average of 11%. Health care is very important here. We in medicine must realize health care roles and responsibilities are changing. We must prepare to handle these changes, whether medically or politically.

Block grants are but a small part of the total health care picture, but it is a beginning in a change of direction. I urge you to join me in reckoning with these changes, and participating in them.

- Dr. Hodes, 238 E. Davis Blvd. Suite "H", Tampa 33606.

Economic and Legal Controls of Health Care in the '80s: Wither Regulation?

Gary J. Clarke, J.D.

Stated in its simplest terms, regulation is *any government action affecting private interests*. That is a very broad definition; yet it most appropriately captures the variety of commentary and criticism of government regulation of the health care industry in the past 15 years. To illustrate the aptness of the definition however, contrast the payments made to an individual physician or hospital by Medicare and those made by a private insurer like Aetna or Prudential.

In the case of Medicare, there are statutes, regulations, guidelines, forms, lawyers, hearings, and even appeals to a special Provider Reimbursement Review Board. That, as we all know, is regulation; yet, Aetna or Prudential also will have guidelines and forms, and even lawyers and appeals that may be every bit as difficult as Medicare. Both Medicare and the private insurers are attempting to do the same thing: purchase health care at the cheapest cost for their clients. The main difference, I suggest, is that government—with all its necessary attention to the rules of law and politics—is doing it in one case, and private industry is doing it in the other.

Sources of Regulation

Traditionally, the sources of regulation are at least threefold. The first source stems from that old American feeling that "There oughta be a law." Regulation is a time-honored attempt to correct inequitable, unfair and outrageous situations occurring in the marketplace.¹ Both quick-fix and long-lived solutions typify this kind of regulation, which includes not only a plethora of licensing programs, but also such varied regulation as the Interstate Commerce Commission, usury laws, the

Securities and Exchange Commission, Workers Compensation laws, and the Federal Deposit Insurance Corporation.

The second source of regulation is based less on a malfunctioning of the marketplace than on a set of economic conditions where goods and resources provided by private firms are either so enmeshed in the public welfare; or do not lend themselves to competitive forces; or are natural monopolies (in the sense that one firm can serve an area better than two); that some form of government regulation is required.² State regulation of telephone and power companies are two noteworthy examples.

The third and the most important and pervasive source of government action affecting private interests (i.e., regulation) stems not from a desire to "regulate" at all, but rather from public decisions that government should provide certain goods and guarantees to its citizens. Highways, welfare, and even education were once provided only by private firms and individuals, but now are so thoroughly enmeshed in the programs and policies of our federal, state and local governments as to be practically inseparable from them.

Health Care Regulation

Regulation of the health care industry stems from all of these causes. Our licensure laws for health professionals stem as far back as abuses occurring in the 19th Century; our certificate of need and hospital rate regulation laws stem from economists' arguments in the late 60s and early 70s; and our major fiscal involvement as a purchaser of services stems from the Medicare/Medicaid enactment of 1965. It is this latter step—made in an attempt to provide needed health services to the poor and aged, not to regulate—that has most emphatically involved government in the business of regulation of the health care industry. And it is this same commitment that will make the continuation of some form of economic regulation of health care inevitable.

The Author

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The facts speak clearly for themselves. In roughly 30 years from 1950 until today, the percentage of Gross National Product devoted to health care services has more than doubled, from 4.6 per cent to 9.4 per cent.³ At the same time, government spending for health care has risen geometrically. In 1965, shortly before the passage of Medicare and Medicaid, total federal expenditures for health care amounted to less than \$6 billion.⁴ Today, Medicare alone will cost approximately \$55 billion, while Medicaid—a shared federal and state program—will cost another \$35 billion.⁵ According to our own Hospital Cost Containment Board, total government expenditures in all Florida hospitals now account for about 56 cents of every dollar of revenue.⁶ In the nursing home industry, the Medicaid program accounts for about 57 per cent of all revenue.⁷ And in both cases, because most government programs do not pay the full charges of institutions, the actual volume of patients and costs attributable to government programs is even higher.

As a result, the question of regulation of the health care industry—ignoring all the certificate of need laws, licensing laws, PSROs and utilization reviews ever invented—is moot. By reason of the sheer size of governmental involvement, regulation is not only inevitable, it occurs by definition. Whatever government does or does not do, it will have the single most important impact on the economic health of the industry. Thus, what I am suggesting to you is that the question for the 80s is not *whether regulation?* but rather *how regulation?* *by whom?* *to what purpose?* and, most importantly, *what effect?*

“Regulation” and “Competition”

The entire debate in Washington and elsewhere today has been characterized as a debate between “regulation” and “competition,” somehow inferring that if we only did away with what we have today we would have no more regulation. This may be important rhetoric for the campaign trail, but it is fuzzy thinking and misleading at best. It is a close sibling for that other piece of health care rhetoric so dear to liberals and conservatives alike—“If only we could do away with fraud and abuse we would have plenty of money to solve all of Medicaid’s cost problems.” Jargon and slogans will neither solve the problems nor delay the inevitable changes that will occur in the 1980s through government action—no matter what banner flies over the battle.

The problems facing government policymakers as a result of the Medicare and Medicaid commitments cannot be underestimated. While public opinion surveys report that the public is generally pleased with its health care, and only mildly concerned about costs,⁸ government officials cannot be so placid. Faced with tax revolts and their own promises to get government off the backs

of the people, officials cannot simultaneously fulfill the promises of 1965. Costs for Medicare and Medicaid are literally out of control and promise, given the increasing age of the population and continuing health care inflation, to get worse.

At the federal level, health care now consumes 14.6 per cent of the total federal budget.⁹ Over the past five years, Medicare costs have risen an average of 18 per cent per year—meaning the program will roughly double in size every four years!

The growth of entitlement programs as a whole has threatened the entire federal budget process. In 1980, the Office of Management and Budget estimated that 76 percent of the entire federal budget was consumed by so-called “uncontrollables”¹⁰—meaning those items like entitlement programs and interest on the national debt over which the President and the Congress have no budgetary control except by fundamental changes in law that require cutting back on the commitments made to budgetary control except by fundamental changes in law. Some analysts estimated that even before President Reagan’s tax reduction package, normal growth in the “controllables” would consume the entire federal budget by 1985 or 1986.

When he was a Congressman, David Stockman sounded an early warning to the difficult policy decisions that lay ahead. Congress, he said, was becoming “a green eye-shaded disbursement officer who totes up the bill, writes the check, and then trundles off to the chapel to mourn.”¹¹

Medicaid Expenditures

At the state level, problems may be even worse. Over the decade of the 1970s, total state Medicaid expenditures rose three times faster than total state revenues.¹² In several northeastern states, including Massachusetts and Rhode Island, the Medicaid program alone accounts for about 20 per cent of total state expenditures, while in others, Medicaid expenditures may be twice as large as AFDC expenditures.¹³ Yet since 1975, vastly increased expenditures for Medicaid have brought no new clients into the system, but rather followed the general price spiral in the health industry. As a result, it is little wonder that some states have rushed headlong into a public utility approach to regulation of the hospital and nursing home industry.

Moreover, the pressures on state officials are likely only to get worse. One group of economic forecasters has predicted that state revenues (considered nationally) will rise only about 1.9 per cent during the 1980s—less than a third the average increase in revenues in the 1970s.¹⁴

Given these problems, it is little wonder that some governors have called for a complete turnback of the Medicaid program to the Federal Government. Others,

however, being more suspicious of the Federal Government after receiving the "empty envelope award" at the conclusion of the health bloc grant debate, have been extremely reluctant to embrace either the President's "swap" program or his competition strategy.

Given these same fiscal problems, it is also little wonder that Secretary Schweiker suggested a possible cap on the entire Medicare and Medicaid program. The announcement signals a tough approach to regulating health care costs from a "pro-competitive" Administration. The announcement was noteworthy, however, not for its content but for the noticeable lack of outcry from the health industry. The Carter Administration was practically flailed alive for thinking such thoughts, much less publicly proposing them.

What then, will be done in the present decade? What types of regulation might be implemented by our federal and state legislators in the years ahead? Two years ago, at a conference conducted by the University of North Carolina, I was asked to make similar projections, most of which bear repeating, while others, which assumed another four years under a Democratic presidency, are best left to the past. Quite accurately, I think, I predicted a new confidence in the abilities of state governments to carry out their programs that would result in considerably more transfer of power to the states than had taken place in the 60s and 70s. I also predicted an eventual nationalization of Medicaid, of health insurance regulation, of professional licensing standards, and of facility licensing standards. These trends are presently underway, although with a speed I did not predict.

Where I completely missed the boat was in predicting that states would become important—indeed pre-eminent regulators of the health care market place. Assuming adoption of some kind of national catastrophic health insurance program, I naively assumed the powers for controlling costs in that system would be delegated to the states. Indeed, the experience of other countries suggests that most have followed their traditional federal system in delegating responsibility for carrying out such national health programs.¹⁶

The Reagan Proposals

The Reagan Administration, however, with its fundamental and even radical proposals for reform of the health care system has laid waste to such projections. Instead, what the Administration has set forth is an agenda that essentially calls for pre-eminence of a whole new set of characters—some not yet even on the scene—that may achieve, as far as the private practitioner is concerned, a position as "regulator" far more pervasive and invasive than any government regulator devised to date.

Indeed, I predict that when this conference is held in the year 2000, someone will stand at this podium and hark back to the halcyon days of the 1970s, when there was a comparatively small, abusive, and yet relatively weak set of acronymed regulators, while the money flowed freely for all involved. Indeed, Alex McMahon, President of the American Hospital Association, already has stated that if only hospitals could return to the Medicare principles of 1966, all would be well.

U. Reinhardt, in a humorous article entitled "Table Manners at the Health Care Feast," aptly summarized from an economist's point of view the debate that will characterize the regulation of the 80s.¹⁷ The 50s and 60s, he noted, were a period of time when the food at the health care table was plentiful, and the guests were scarce. As a result, society invited more and more guests (hospitals, physicians, nurses, physicians assistants, nursing homes, ambulatory surgical centers, and the like) to sit at the table. Now, in the 80s, it will be the guests who are plentiful and the food that is scarce.

How, he asks, will society set the table manners (or the rules of economic regulation) for the guests? Will there be any rules at all? Or any limitation on the guests? Will the guests themselves set the rules, and determine not only who shall eat, but how much? Or will government do all of these things for us? Certainly, it is that latter situation that is most abhorrent to us, yet the prospect of no rules—of anyone providing medical care or insuring it—is undoubtedly equally repulsive. Yet government cannot possibly feed all the guests that are crowding around the health care feast in the manner to which they have grown accustomed.

End to Subsidies

Something must give, and I expect the first sign is Secretary Schweiker's call for a cap on Medicare and Medicaid. The second is a probable end to tax subsidies for third party health insurance, possibly before the end of this legislative session. The third sign, not yet unveiled, will be a radical retrenchment from the open-ended entitlement nature of Medicare and Medicaid. Instead of agreeing to pay for services deemed medically necessary, the Administration undoubtedly will seek a flat payment, with no further financial obligation, for each Medicare and Medicaid recipient (also known as vouchers). As a result of these, and a few other fine tuning changes, I think the new regulations and regulators of the 80s, interspersed with some of the old ones, will emerge of economic necessity.

The New Regulators

The new regulators, to no one's surprise, are expected to be the health insurance companies, the hospitals, big business, HMOs, large group practices, a

certificate of need agency and hospital cost board in a few states; a nursing home regulation commission in virtually every state; and here and there, a consumer group. That is certainly an odd lot of non-traditional bed fellows in the health care industry. Their tasks will be how to make these limited government dollars stretch further than they have in the past; how to mitigate the worst aspects of the two class system that will inevitably result from limited government dollars; to ration the supply of nursing home services; and to assure that essential research and teaching continues to be carried out.

Physicians will find that while they deal far less with government than today, their style of practice will be affected far more by the simple lack of money than by any regulation yet devised. Accountants, computers, non-physician medical managers, and most importantly, physicians themselves will oversee the practice of their colleagues to a far greater extent than is the case today. All sorts of bargaining between physicians and insurance companies, hospitals, nursing homes and other facilities, as well as bargaining within corporations like prepaid group practices, is likely to become extremely prevalent. And like other sorts of collective bargaining, more issues than just compensation—like conditions and hours of employment, quality of production, and output—are likely to be at stake. In short, economic regulation of the government expense of Medicare and Medicaid is likely to bring about far more change in medical practice through indirect fashion than all the change of the supposedly regulatory-oriented 1970s.

Traditional Regulatory Schemes

In addition, here is what I predict the more traditional regulatory schemes will look like in the 1980s. First, professional licensing will solely utilize national examinations as a method of entry into the professions, and concentrate most of their efforts on case-by-case solutions to problems of incompetency. In addition, the already hazy lines between professions will become even hazier as new corporations experiment with more cost-effective ways of delivering health care. Unlike the past, however, the new corporations will have the political clout to overcome the professional jealousies that have led to continued attempts to draw strict legal lines around the various professions engaged in the healing arts.

Second, I predict the medical malpractice crisis will again visit us with a vengeance. Eventually, however, the widespread practice of medicine in large groups and corporations, with the attendant overseeing of quality of care and spreading of risk, will moot this issue for all but the rare physician in solo or small practice.

Third, I predict that regulation of medical records and patient confidentiality will become a major issue.

Greater patient movement between large, competing corporations will require easier transfer of records to expedite quality of care. At the same time, confidentiality will be paramount to both the patient and the corporation, for corporations will compete to avoid adverse selection while keeping the healthiest of patients to themselves. Indeed, could it be that fully documented medical records actually contain "corporate secrets" as to how one corporation delivers more cost-effective care than another?

Fourth, I predict that health facility licensing will apply solely national standards, with state and local health departments involved primarily in complaint investigations and monitoring.

Fifth, I predict that health insurance regulation will be carried out according to national standards that include standards for marketing of policies, minimum benefits, and various financial requirements. Again, state agencies will be involved primarily in complaint investigation and monitoring.

Hospital Rate Commissions

Sixth, if not preempted by the Reagan Administration, *I predict certificate of need regulation and hospital rate commissions will continue in most of the urbanized states. Certificate of need programs will look very different than they do under the soon-to-expire mandate of P.L. 93-641, but will exist for major new construction in a more traditional public utility type approach. Also, unless the Reagan Administration acts quickly on its competition strategy, hospital rate commissions may even grow in numbers in the 1980s as hospitals, particularly those with major teaching responsibilities or located in inner city areas, are devastated by an accelerating trend of government cost-shifting.¹⁸

Seventh, I predict that regardless of the fate of certificate of need and hospital rate review programs, nursing home regulatory review programs will spring up in every state. The cost and quality problems of nursing homes have thus far proved intractable not only in practice, but even in theory. The rapid aging of our population and the attendant costs practically beg for a public utility approach to ration benefits until better alternatives can be devised.

Eighth, I predict that if competition really does take hold by the end of the 1980s, there will be a new cry for regulation of the HMOs, prepaid group practices, and other organizations that emerge. The fight for wealthy market areas, for physicians and physician privileges, for consumers, and for control of hospitals and nursing homes may become so intense and bitter that the public and even the physician community will cry out for a new

*For all its statements about "states rights" and Federalism, the Reagan Administration has been curiously eager to pre-empt state regulation in health care.

kind of regulation. I hope, however, such a prediction need not come true.

I do not think things will sort themselves out by the end of the decade. Instead, we will be using old mechanisms of regulation to adjust to new circumstances and will not know quite when or how to give up or change. The cost crisis is inevitable, and as the chasm widens, especially in long term care, something new in terms of financing, organization and regulation will have to be devised.

Conclusion

Finally, I would like to conclude with two thoughts to put this entire discussion into perspective. The first is that the Reagan Administration, while making some radical proposals, has, more than anything else, hurried history along. Growth in entitlements, including health care, had to be controlled. In the process of addressing this problem, however, the Administration has devised a brilliant political strategy that fits its own ideology, that enables the Federal Government to wash its hands of the very difficult question of "who shall live," and that just might work.

The second perspective on this discussion is constantly emphasized by Walter McClure, who states not only that it is no one's fault that we got where we are today, but that our choices from here are very few. Either we set the rules and regulations for competition and see if they work; or we set the rules for a more openly regulated health economy, as every other industrialized economy has done.¹⁹ Whatever emerges is likely to be a pragmatic mix of competitive theories and traditional regulation. In the words of John F. Kennedy,²⁰

What is at stake is not some grand warfare of rival ideologies which will sweep the country with

passion, but the practical management of a modern economy.

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- Mr. Clarke, DHRS, 1317 Winewood Blvd., Bldg. 2, Room 218, Tallahassee 32301.

The Physician's Role in Health Care Financing and Delivery

James H. Sammons, M.D.

Let's look at the role of the physician and that of physicians collectively from several viewpoints. What we can do together most effectively at the national, state, and local levels, and what we can do as individuals, varies, as you know.

First, on the national scene, the American Medical Association (AMA) serves best as the organization representing all physicians, a role that our members see as our most important one. The AMA can and should identify nationwide problems in the health care system and help develop and promote promising solutions for them. We can and should identify upcoming changes that will affect medical care provision patterns and financing patterns.

Right now, we can foresee some very pronounced changes ahead. Most of these changes are evolving from the new political climate in Washington, from the swelling pressures to make health care more cost effective, and also from a pronounced trend toward what is popularly known as "competition" in the financing and delivery of care.

Public and political concerns about rising health care costs will continue to exert strong influence on physicians and organized medicine in this decade, and we must respond with the immediacy and directness that those concerns demand. At the same time, however, I think that we should occasionally remind our critics that there are some very good reasons for these cost increases. For example, the Department of Health and Human Services has determined that almost three-fifths of the increase in personal health care costs from 1965 to 1980 can be attributed to price inflation, while the rest was due to population growth and to greater intensity of care, such as increased capacity to diagnose and treat illnesses and injuries, and more patient visits per capita.

So, on the national level, we can help make those critics who blame physicians alone for rising costs aware that they should examine *all* the facts.

The AMA Role

In the development of national health care policy, the AMA must play an important, responsible role on several fronts. We must always remain aware of our strong, continuing commitment to maintain and improve the science and art of medicine—our goal from the beginning. This commitment compels us to testify before Congress and to give our opinions to administrative and regulatory bodies on proposals that would affect medical education, research, and general scientific policy. More than half the 88 statements presented in Washington by the AMA in 1981 dealt with scientific and educational issues.

On the socioeconomic scene, we can be proud of our activities related to the organization, delivery, and financing of health care. Early in President Reagan's Administration, the AMA recorded its support for his plan to defederalize and to deregulate, in some ways, the health care system. We are pleased that the new Congress has been generally supportive of the President, who has shown strong leadership abilities. His plans to reverse the tide of federal government spending and power and return many responsibilities to the states are commendable.

But, the Reagan Administration has made clear its concern about cost increases. Unless we in the health care arena can voluntarily restrain costs, Congress may very well opt for a "regulatory" solution. And that solution, according to Dr. Robert Rubin, Assistant Secretary of Health, "... would make the Carter Hospital Cap proposal look like a free-market approach."

The AMA is studying current proposals and Department of Health and Human Services plans for so-called competition programs. While we support many concepts in the "consumer choice" plans, we cannot support the bill introduced by Representative Gephardt of Missouri. We oppose that bill because we believe it would lead to wide-open, misdirected competition and to more, not less, federal control of health care.

The Author

JAMES H. SAMMONS, M.D.

Dr. Sammons is Executive Vice President of the American Medical Association with headquarters in Chicago.

"Pro-Competition"

Let's examine what is meant by "pro-competition." We find a problem here. How one person or group perceives pro-competition can differ vastly from the way others perceive it. People in government generally see it as extending the range of health insurance benefits and the health care delivery options available to consumers. In the private sector, hospital administrators and trustees may see it in terms of hospitals competing with each other and in terms of hospitals competing both for and with physicians.

To an economic purist, competition means virtually unlimited numbers of providers in a health care marketplace in which licensing would be all but eliminated and "classes" of healers might appear in its place. As physicians, we might find ourselves sharing patient care with a range of other people including, perhaps, some patent medicine types, who would be allowed to deliver health services in hospitals, storefront clinics, department store clinics, or wherever, with patients expected to somehow make rational, informed choices regarding the best — and safest — options for treatment.

Through a newly defined Center for Health Policy Research, the AMA has been studying the effects of "competition" in the medical care sector, the effects of increasing debt on medical education, and physician productivity. Still more activities of the AMA have direct or indirect relationships to delivery of medical care. For example, we have been successful in carrying our appeal of the Federal Trade Commission's advertising case to the U.S. Supreme Court. We have also developed an up-to-date set of ethical guidelines for physicians along with new opinions of our Judicial Council that directly address some of the ethical dilemmas of modern medicine.

Health Planning and PSRO

While we continue to seek repeal of both the Health Planning and the PSRO laws, we have also developed a set of comprehensive guidelines for effective local planning programs, and we are encouraging local medical societies and physicians to *strengthen* existing peer review and utilization review mechanisms without reliance on federal support.

We continue to support strongly the stable government funding of medical research and medical education. The AMA supported The Administration's decision to maintain an emergency fund for medical schools in financial distress, including schools with large numbers of minority students, and to maintain a program providing guaranteed loans to medical students. We believe that the future provision of medical care is dependent upon assuring that students from a broad variety of backgrounds can complete medical training.

Still staying with the AMA's role on the national scene, I'd like to point out our predominance in the medical publishing business. The AMA disseminates more medically related information than any other publisher.

While this may not appear at once to have much to do with the financing and delivery of health care, a little thought will link up the "information explosion" to changes that new technology—new science, if you will—have on delivery and financing. The AMA, in a new, joint project with General Telephone & Electronics (GTE), expects to "tame" some of that information explosion by offering to physicians and hospitals computer terminal access to such scientific information as data on drugs, tests, etc., and eventually to actual clinical protocols and to socioeconomic information.

Two other AMA actions on the national scene offer great promise in improving efficiency and cost-effectiveness in health care.

AMA Cost Effectiveness Program

First, the AMA's Cost Effectiveness Program for 1982 is continuing with the ambitious activities developed last year. Briefly, these include developing a 75-hospital network to monitor results of cost-effectiveness proposals, conferences with other medical societies to develop plans, publication of helpful materials through a national exchange "network," and pamphlets aimed at helping consumers make intelligent choices about health care.

Second, the AMA earlier this month became a member of a national coalition with representatives of business, labor, hospitals, and health insurers. One function of the group is promoting development of local coalitions; some 130 are operating or in the planning stages already.

It is an over-simplification to say that state medical associations generally do at their level what the AMA does on the national level. Many activities are parallel; however, the priorities and the extent of involvement in various activities are bound to differ from state to state.

Growing State Responsibilities

State medical associations are seeing their responsibilities grow. As block grants have become the replacement for many categorical grants, state governments have faced the need for determining the equitable distribution of funds among programs and of setting priorities. In this, the state medical association could play a leading advisory role.

Since the President did not get his "two block" proposal and the additional administrative flexibility he felt needed to try and offset spending cuts, we can expect that attempts to gain these will continue. And, it seems apparent that reduced federal funding will affect not only

health care programs, but such other areas as welfare, roads, mass transit, education, and the like, meaning that competition between health and other programs for funds will be intensified.

State associations can seek to assure that health programs are not "short changed."

Local Medical Societies

And what is the role of the local medical society? In my opinion, local medical societies will have many opportunities to help shape the future of medical care in their areas. And using local solutions to solve local problems is the time-tested, superior approach.

The local coalitions mentioned above, in areas where they are developed, will offer the opportunity for medical society representation. The AMA's adopted policy strongly supports health care coalitions "that include meaningful physician participation, so that primary emphasis is given to quality medical care, including availability and access, as well as recognizing the importance of cost-effectiveness and cost-containment."

The Individual Physician

The role of the individual physician in health care delivery and financing is a matter of personal choice. We in organized medicine can only urge each physician to become involved, to become committed to increasing efficiency and cost-effectiveness in the office and in the hospital—everywhere medicine is practiced, for it is only when every physician, every group practice, hospital medical staff, medical school, and medical society cooperates in finding practical solutions to the problems of today and tomorrow that the promise of the 1980s will be finally fulfilled.

Florida's physicians, with their concern demonstrated by holding such meetings as the 1982 FMA Leadership Conference on Health Care Financing, are rising to meet the challenge, and I firmly believe that all of America's physicians all over our country will meet that challenge.

- Dr. Sammons, Exec. Vice-Pres., AMA, 535 N. Dearborn St., Chicago, IL 60610.

The Florida Medical Association's Involvement In Health Care Financing

Charles P. Hayes, Jr., M.D.

Since its founding more than a century ago, the Florida Medical Association has given medical economics a very visible and high priority position on its program agenda. Program activities have been carried out directly by the present-day Council on Health Care Financing and its predecessor, the Council of Medical Economics; and indirectly through such affiliated organizations as the Florida Medical Foundation (FMF), the Florida Physicians Association (FPA), and the Professional Insurance Management Co. (PIMCO). The FMA Board of Governors and the House of Delegates have orchestrated the major and basic policies with which these operating entities work.

There once was a time when *all* FMA business, including economic affairs, was handled by the seven doctors who were the officers and Executive Committee of the Association. This arrangement seemed to suffice from the beginning in 1874 until 1933, when FMA President William M. Rowlett, M.D., of Tampa, appointed the first Committee on Medical Economics (Figure 1). It is interesting to note that the Committee began service the same year that Franklin Delano Roosevelt and his New Deal took up residence in The White House.

Dr. Rowlett's fledgling committee went to work immediately. By 1934, it had met six times, published two preliminary reports in *The Journal of the Florida Medical Association*, and submitted a seven-page report to the House of Delegates. One of the six meetings involved officers of the component medical societies, and this may have been FMA's first Leadership Conference, which in recent years has become a major annual activity.

The Author

CHARLES P. HAYES, JR., M.D.

Dr. Hayes, Chairman of the FMA Council on Health Care Financing, is a privately practicing nephrologist in Jacksonville.

Figure 1

1933 — 1960

Medical Economics Committee
Representatives to Industrial Council—1937
Special Committee on Prepaid Hospital and Medical Care—1944
Medicare (Champus)—1957
Blue Shield Advisory (Committee of 17)—1957
Commercial Health Insurance—1959

The First Report

A glance at that first report to the House of Delegates reveals that some of the economic topics of that day are still of interest today, although perhaps in different form. The first Committee on Medical Economics was concerned, for example about public responsibility for payment for indigent care; examinations and vaccinations for school children; the role of salaried government physicians; advertising by physicians; cults; and unethical practitioners.

One matter, addressed in some detail was the presence in Tampa of "mutual benefit societies," organizations owned and controlled by (in some cases) physicians and elected lay executive bodies. They were reported to "build hospitals, hire doctors on salary basis and also contract certain highly specialized branches of medicine to the lowest bidding doctors. The society sets the fee and asks for bids. By this method of chiseling down fees, they are able to continue to operate at the expense of the medical profession; a thing to be condemned." These mutual benefit societies were a forerunner of what we call Health Maintenance Organizations (HMO) today.

The Committee also anticipated the passage of Florida's first worker's compensation law, which after enactment led to the appointment, in 1937, of an FMA committee to deal specifically with the Florida Industrial Commission, which administered the program.

The next benchmark year for medical economics in Florida was 1944, when the FMA House of Delegates

adopted a resolution endorsing the establishment of a prepaid medical insurance program. In 1945, the Florida Legislature provided the enabling legislation, and the following year, Blue Shield of Florida was born with FMA sponsorship.

The Middle 1950s

A number of new problems surfaced in the middle 1950s, including the first signs of trouble in the professional liability insurance arena. Problems with third parties prompted the appointment of two new advisory committees, one for Blue Shield (commonly called the Committee of 17), and the other for the military medical insurance program that we now call CHAMPUS.

In 1959, a committee for private health insurance was added, and the rapidly increasing number of problems requiring specialized committee treatment led to changes in the FMA By-laws that set up today's council and committee structure.

Figure 2

1960 — 1974
COUNCIL ON MEDICAL ECONOMICS
Industrial Medicine—Deleted—1965
Medicare (Champus)—Deleted—1967
Member Insurance—Deleted—1972
Blue Shield Advisory (Committee of 17)
Commercial Health Insurance
Fee Schedule—Relative Value
Hospital and Extended Care Facility—1968
Professional Liability—1971-1973
Peer Medical Utilization Review—1971
Computer—1971

The Original Council on Medical Economics had five committees (Figure 2). Some of these committees were disbanded and others added as the needs of the FMA changed. For example, three committees that dealt with similar fee schedule problems were consolidated into a new Committee on Fee Schedules, which evolved into our present Committee on Relative Value Studies. The responsibilities of the Member Insurance Committee were transferred to the FMA staff. Initially, Harland-Med and later PIMCO were established to assist in the management of FMA-sponsored insurance programs. The Hospital and Extended Care Facilities Committee was established to develop model hospital staff by-laws, which was accomplished in two years. The Peer Medical Utilization Review Committee was established in 1971 to provide professional peer review by practicing physicians for the Medicare program. Over the years, many of these committees have had minor name changes, but their mission remains the same.

Figure 3

1974—1979
COUNCIL ON MEDICAL ECONOMICS
Health Insurance
Relative Value
COUNCIL ON MEDICAL SYSTEMS
Foundations for Medical Care—PRO
Government Programs
PMUR
H.S.A.—1978

Council/Committee Reorganization

Because of the continued growth of these problems, the FMA councils and committees were reorganized in 1974 (Figure 3). Committees dealing with government programs were placed under the new Council on Medical Systems, leaving committees dealing with economic issues under the Council on Medical Economics. The Council of Medical Systems included new committees dealing with Foundations for Medical Care, Health Planning, and Government Programs. This format endured until 1980, although there was a realignment of councils and committees in 1979 (Figure 4).

These changes were minor, although the Cost of Medical Care committee was transferred from the Board of Governors to the Council of Medical Economics. Activities of the Council on Medical Economics were shifted to the newly created Council on Government Programs.

Figure 4

1979 — 1980
COUNCIL ON MEDICAL ECONOMICS
Relative Value
Cost of Medical Care
Medical Delivery Systems: Found./HMO
Admin. Med. and Management
COUNCIL ON GOVERNMENT PROGRAMS
H.S.A.'s
H.R.S.
Medicare
Worker's Compensation

In 1980, the activities of the Councils on Government Programs and Medical Economics were combined into the Council on Health Care Financing (Figure 5). Last year's council was composed of the first five committees. In 1981, five other committees were added.

The Council on Health Care Financing

As previously mentioned, the Committee on Workers' Compensation dates back to 1937, making it

the longest continuous medical economic activity of the FMA. In recent years, the principal challenge facing the Committee has been achieving fee parity with other private insurance plans. In addition, this Committee has been working to establish appropriate relativity in the Workers' Compensation fee schedule.

It can be reported that the Committee on Worker's Compensation has negotiated a 35 to 40 per cent increase in the Workers' Compensation Fee Schedule for 1982, and for the first time, this fee schedule will be based upon *statistically valid physician charge data*. We expect the Division of Worker's Compensation to publish the fee schedule as a rule in the near future. There is reason to believe the 1983 fee schedule will more closely approach "usual and customary."

Since the fee schedule for Worker's Compensation is to be based upon historic physician charge data, it is essential that those physicians who treat Worker's Compensation patients submit their usual charges even though they will not receive that amount. This is the only way valid charge data can be gathered to establish appropriate relativity and level of reimbursement on an annual basis.

Committee on RVS

The Committee on Relative Value Studies dates its origin to the Fee Schedule Committee established as a part of the Council on Medical Economics in 1960. This Committee was created primarily for consolidating all of the fee schedule problems arising from the proliferation of third-party payors such as Worker's Compensation, Blue Shield and Medicare, Champus, and private insurance companies. One of the first efforts of the Committee was to prepare and publish the *1962 Florida Relative Value Studies*. Updates of the Florida Relative Value Studies were published in 1968, 1971 and 1975, and each succeeding product has benefited from improvements in the fee survey techniques. This year's Relative Value Studies Committee has worked hard to complete the *1982 Florida Relative Value Studies*. This RVS has

two new features: (1), it is using only CPT-4 codes and descriptors; and (2), the relativity between procedures is derived entirely from physician charge data. We expect the *1982 Florida Relative Value Studies* to be delivered by May 1, 1982.

Committee on PROs

The Committee on Peer Review Organizations has been negotiating a new Peer Medical Utilization Review contract with Blue Shield and HCFA that will maintain quality peer review despite severe budget cuts. Also, this Committee is working in cooperation with the Committee on Business and Industry Relations to develop future utilization and peer review programs that can be made available to business coalitions. This will provide us the opportunity to conduct comprehensive peer review not only for governmental programs but also health care programs supported and funded by the private sector, and prevent expansion of review organizations composed of professional reviewers rather than practicing physicians.

Committee on Health Planning

Our Committee on Health Planning continues to monitor both federal and state government health planning activities, and the activities of two legislative advisory task forces dealing with the role of the state in health planning after the Federal Government withdraws.

Government Programs

The Committee on Government Programs monitors and reviews on a daily basis numerous actions on the part of both federal and state government agencies that deal with health care. This year the Committee was instrumental in focusing official attention on some inappropriate procedures that served no useful purpose. Appropriate steps were taken.

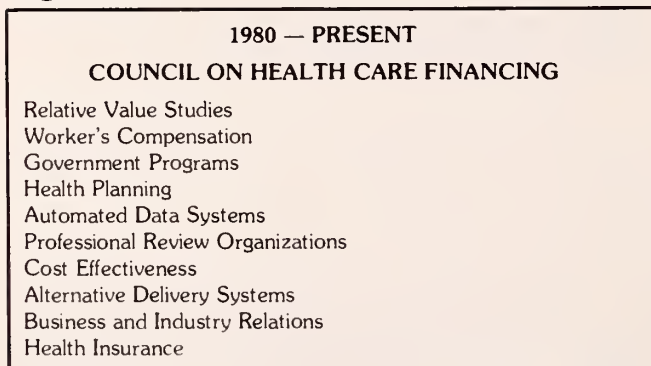
Data Systems

The Automated Data Systems Committee continues to work with the Committee on Peer Review Organizations assessing the data systems applications to utilization review. The collection, handling, storage and use of data continues to be a major interest of the Council.

Cost Effectiveness

The Cost Effectiveness Committee represents the Florida Medical Association in the Florida Voluntary Effort, which is undergoing a self-assessment of its future role in light of changes in our nation's economic environment.

Figure 5



Insurance and Alternative Delivery Systems

The Health Insurance and the Alternative Delivery System Committees have been examining proposed changes in the financing of health care delivery. Concentrated attention has been given to the potential impact of the "competition" economic theories on physicians and patients. A position paper has been drafted by the Health Insurance Committee and will be submitted to the Board of Governors. Also, the Committee on Alternative Delivery Systems has developed a position paper on HMOs which will also be forwarded to the board. These position papers will help clarify the potential impact, both good and bad, of these two highly controversial issues for Florida physicians.

Business and Industry Relations

The Committee on Business and Industry Relations is working closely with many of the other committees of this Council in developing the necessary support materials needed to work with business coalitions. The Committee has worked closely with FMA President Sanford A. Mullen, M.D. in an effort to involve physicians in local business coalitions. The President and Committee members have met with South Florida, Hillsborough County, and Jacksonville coalitions to explain the importance of physician participation in their future development. In addition, they met with the leadership of the Orange County and Capital Medical Societies, and plan to meet with the Escambia County Medical Society in the near future, to provide them with useful background information and support as they prepare to work with the business leaders of their communities.

Our Council continues to be concerned over the apparent reluctance of some business coalitions to involve physicians and others of the industry. Our President has met with Gov. Bob Graham (who sparked the development of the South Florida Coalition) to obtain his support for including physicians in the membership of future business health care coalitions that are stimulated by his office. Mr. Peter O'Donnell of the Governor's Office expressed such a spirit of cooperation by the Governor toward medicine in his remarks to the national industry council for HMO development in late January. The services of that committee on business and industry relations are available to meet with any county medical society upon request when it wishes to become involved with a business coalition in their community.

State Medical Association Survey

Because of our interest in how the Florida Medical Association compares with its sister state organizations around the country, a letter was sent to the 49 other state medical associations seeking information on their

Activities comparable to that of the Council on Health Care Financing. Nineteen of those surveyed responded (Figure 6).

The state associations varied in size from California and New York, (membership more than twice that of FMA) to Wyoming, which has a staff of three to serve its 450 members. There are seven county medical societies in Florida that are larger than Wyoming's Medical Association.

It appears that most state societies, including Florida, are dealing with similar problems. However, there is some variance in approach. The three smaller state societies handle all business at board, ad hoc committee and staff level. At least one-half of the other 16 respondents have organizational units similar to the committees that make up our Council on Health Care Financing, except for the Committee on Automated Data Systems.

Figure 6

STATE MEDICAL ASSOCIATION SURVEY

- 19—Responses
- 3—Board, Officers and/or Staff
- 14—Cost Effectiveness
- 12—Health Insurance and Alternative Delivery Systems
- 11—P.R.O. and Government Programs
- 10—Worker's Compensation
- 9—Business and Industry
- 8—Health Planning
- 3—Data Systems

The Future

The Florida Medical Association must be prepared to assist its membership in dealing with what promises to be over the next few years a rapidly changing environment for both physicians and their patients. There is concern that the options currently under discussion at the national level with their focus on cost containment will compromise access to, and quality of, care, thus changing the health care delivery system for the worse. Terms such as "pro-competition," "consumer choice," "first-dollar coverage," "regulated competition," "HMOs," "free-choice," "national standards of medicine," "standard of basic coverage", and "open hospital privileges" are taking on new and varied meanings as they are applied to the health care field. Because of rapid change, organized medicine must have the ability to clarify the issues for its members.

Of major concern is the emergence of the "pro-competition" economic theories that are popular with both government health policy makers and business leaders. Although it is unclear just how well some of the new concepts will be received in Congress, it is striking to note the change taking place in the attitude of our

political and business leaders that permit these theories to be given serious consideration.

Because of pressures from government and business, there is likely to be an expansion of pre-payment programs such as HMOs and IPAs, since they present the only form of "pro-competition" with which there has been any experience. These issues are discussed in some detail elsewhere in this issue of the *Journal*. There are several questions that should be answered by the proponents of "pro-competition" before a \$247 plus billion industry is completely revolutionized. Some of these questions are:

- It is implied that the "risk-taking" of the pro-competition proposals is limited to insurers and providers. Is that really true?
- Isn't the employee at risk if his health insurance plan bankrupts in the competitive market place?
- Who pays the non-covered bills of the employee who, when offered several "consumer choice" options, selects the "cheap choice" insurance plan and later develops an expensive illness?
- Doesn't the premium of the "comprehensive full-coverage choice" become prohibitively expensive when only employees with potential expensive illnesses select it? How is this adverse selection prevented?
- What happens to quality considerations by providers when competition becomes intense?
- It has been estimated that 20 per cent of the health care expenses pay for physicians services and 40 per cent is paid for hospital care, they are the focus of the "pro-competition" theories.

Therefore how does this approach contain the other 40 per cent of the health care dollar that is expended on extended care facilities, nursing homes, home health care, drugs, transportation, etc., where some of the most notorious scandals have occurred?

- How will the rapidly increasing direct and indirect costs of professional liability be contained under "pro-competition?"
- How will the rapidly escalating salaries of nurses and other health care workers, long overdue, be absorbed?
- How can a business health care coalition analyze the health care industry without the knowledge and experience of that industry's experts, i.e., physicians and hospital administrators?

It is organized medicine's responsibility to get these questions, and others, to the right people for answers. This brief review of FMA's involvement with medical economics points out that it has maintained a vital interest in all aspects of the problem. Many of the problems have persisted through the years; others were solved once, only to recur later. FMA shares many problems with other state medical associations. One thing is certain: there will be a need during the foreseeable future for FMA to carry out the duties of a council on health care financing, by some way or other to wrestle with the changing world in which its membership practices the science and art of medicine.

- Dr. Hayes, 2005 Riverside Ave., Jacksonville FL 32204.

Cost Containment and Quality Assurance

Samuel B. Tibbitts

The issue of quality of care has grown to encompass an expanding set of concerns. Trends in the 1980's mandate an even broader definition of quality of care. The traditional concerns of quality of care were limited to the technical quality of procedures, or the qualifications of practitioners. Not much concern was paid to the cost of quality; the motto "quality at any cost" was a byword of the 60's.

There is a need now to widen the scope of quality assurance concerns, to include issues of appropriateness of medical care. The key issue is to increase the productivity of America's health care system while encouraging appropriate use of the high quality care which is a hallmark of our way of life. Refocusing quality assurance efforts toward the location and the time care is provided has the potential to yield substantial benefits to both patients and health providers. There is a major unrealized potential for aligning health care cost containment concerns with concerns for quality of patient care. A renewed concern for appropriateness of care can be supported enthusiastically by organized medicine, by hospitals, by business and industry coalitions, by all types of payors, and by patients alike. Inappropriate care has costs in both human and economic terms.

Centering quality of care concerns on appropriateness of care is one focus of the Voluntary Effort. To its credit, the American Medical Association has developed a comprehensive program which will be distributed to all state and local medical societies as part of the AMA's efforts to make the Voluntary Effort effective. The Voluntary Effort is a coalition of leading policy-makers from major hospital organizations, organized medicine, health product manufacturers and consumer groups who joined together on their own initiative, to voluntarily contain the rate of health care cost increases.

The Author

SAMUEL B. TIBBITTS

Mr. Tibbitts, of Los Angeles, Calif., is a founder and co-chairman of the National Steering Committee for the Voluntary Effort to Contain Health Care Costs.

Traditional Focus of Quality Assurance

Health care professionals have demonstrated longstanding concern for quality assurance. Earlier quality assurance efforts were focused on control of infection, and licensure and certification of professional personnel, all of which remain on the quality assurance agenda today. Other current quality of care mechanisms concentrate on comparing treatments with underlying diagnoses, and on physical evidence of quality, through programs such as tissue review.

The role of the Joint Commission on the Accreditation of Hospitals is well known. Initiated in 1951 by the American College of Surgeons the JCAH is an independent organization which sets structural and procedural standards for hospitals. The JCAH is a successful voluntary program which enjoys the support of providers, consumers, government, business and insurers.

It is to the credit of hospitals and physicians that many quality assurance measures have been developed at the impetus of providers. However, there has been a tendency on the part of providers and patients alike to equate high quality care with expensive care, with high technology care, with elaborate procedures and with the *quantity* of care provided. This concept of "the best at any price" has not always produced optimal care, and has contributed to today's troublesome spiralling health care costs. The combination of the "best at any price" philosophy with the misconception that "more is better" has generated a demand-pull for medical care resulting in substantial over-use of services.

Pressures to Redefine Quality Assurance

A principal victim of these spiralling costs is the business sector, which pays high insurance premium payments and high tax dollars, and which picks up the difference between full fare and what the government pays. A conservative estimate would be that business pays one third of our inflated health care budget. Caught between these rapidly rising costs and a less-than-booming economy over the past five years, business coalitions are working on mechanisms for controlling health care costs.

These coalitions are an increasingly powerful force in the health care field. Coalitions and "Fortune 500" firms are seeking out providers whose concern for appropriate use of care in a productive provider environment matches their own. These coalitions and large firms are developing health promotion efforts, redesigning benefits to promote employee cost sharing, and requiring prior authorization or second opinions for certain procedures. Several have contracted for private utilization review of their hospitalized employees.

Business' increasingly active concern for appropriate and high quality care at a reasonable cost gives providers with foresight a great opportunity for positive cooperative projects with these purchasers of their services. Providers who develop such alliances will find themselves in a strong position in an increasingly competitive health care market. Those who do not will find themselves pressured on one side by government regulation and on the other side by coalition demands for reasonable charges for appropriate services. The power of these coalitions has tremendous growth potential as organized labor awakens and begins to take an active interest in health care expenditures.

Steps in the Right Direction

What can providers, patients, and payors do to ensure that cost containment concerns and quality assurance concerns are aligned? Patients can be educated to understand that the highest technology care, and the most frequent use of care, is not always the most appropriate care. Patient expectations put a tremendous pressure on physicians to prescribe and treat even when the physician might be inclined to wait and see.

However, patients can only be expected to balance their need for care with its cost, when they are paying part of the bill. Insurers, and purchasers of insurance have an opportunity to encourage rational use of the health system by providing proper economic incentives. An example of innovation in this area is California's Mendocino County School District which has instituted a program of providing a cash incentive to employees to stay healthy. The county's health insurance plan has a \$500 deductible; if the employee stays healthy and does not file claims, part of that deductible is returned to the worker in the form of a bonus. In addition to encouraging appropriate use of health care services, this program has resulted in a tremendous increase in health promotion activities initiated by the workers themselves. Businesses are taking a renewed interest in promoting wellness behavior among their employees and, in other steps to reduce their health care cost burden are actively seeking providers who provide an optimal mix of quality care at a reasonable cost.

They seek providers who take steps to reduce their costs by limiting their care to that which is appropriate. One major manufacturing firm has ceased purchasing services from a hospital which will not provide outpatient surgery services. Providers who cannot respond to business pressures to provide least-cost methods for providing appropriate care will find themselves losing business to alternative delivery systems such as health maintenance organizations and preferred provider organizations which can respond to new business imperatives.

Preferred Provider Organizations

Preferred Provider Organizations are relatively new on the scene in terms of alternate delivery systems. They might be described as half way between an HMO and indemnity type insurance. It involves the voluntary networking of doctors and hospitals through a contractual arrangement to provide health care particularly to self-insured companies and union trust funds which have indemnity type programs. The individual employee may choose the PPO and receive full care with or without a deductible and co-payment, but certainly with greater benefits than the indemnity plan.

The secret of success for these PPO's will be quality of care with proper utilization review. Cost effectiveness will come about through these factors by basically following the HMO lead in reducing the number of patient days per 1,000 population and putting patients in the appropriate health setting at the right time. In this type of organization the physician agrees to a pre-determined fee schedule and hospital agrees to discount its charges, to some extent, for prompt payment and no bad debts.

Private insurance companies and self-insured companies, through the use of deductibles and co-payment, and the Federal Government, through the use of tax penalties, can both provide incentives for the appropriate use of medical care. These types of programs cut to the heart of the inflation problem in health care by controlling demand for health care services. There will always be an infinite demand for a free lunch. As the AMA has stated, physicians must increase their awareness of lower-cost through the use of alternative but equally effective procedures and medical settings. Concern for the appropriate setting is a key to appropriateness-based quality assurance.

Outpatient Surgery

The use of outpatient surgical units illustrates this type of substitution. Another area of contribution to this effort is to be wary of new high-cost technological advances which have a marginal return on patient

outcomes. During the training years, physicians can be made aware of techniques and procedures which increase quality without adding greatly to the cost of medical care. Such awareness is important to the young physician entering practice in today's environment.

Hospitals have been singled out by the Voluntary Effort as having a unique responsibility to improve productivity through efficient use of people, materials, energy and plant. Many hospitals have demonstrated support for this effort by developing management engineering standards for maximizing productive staff time, by controlling inventory and use of materials, by conserving energy, and by scheduling to maximize appropriate use of hospital plant.

Administrative staff can also assist medical staff in monitoring procedures and outcomes. Linking tissue review with utilization review and peer review provides medical staff with tools to develop a program which helps ensure that performed procedures are appropriate procedures.

Hospitals and medical staffs can develop risk management programs designed to reduce the human and economic effects of accidents in the hospital environment, and can work with other providers to ensure that low cost, high quality innovations such as outpatient surgery units and birthing centers are available. In short, we can broaden our focus on quality assurance to examine whether the care given is the appropriate care, in the appropriate environment, at the appropriate time. In doing so, we perform a service to the patient and we enhance our own productivity.

Forced to respond to an increasingly competitive environment, hospitals are experiencing competition's pressures to "rationalize" health systems. In today's health care environment, hospitals cannot develop a new service prior to expressed demand; hospitals are discovering the positive power of marketing as a tool for assessing *real* needs and are adjusting service mix to meet those needs.

Conclusion

Health providers are learning that there is a real cost to poor quality. It is essential to increase productivity while ensuring that all appropriate care is high quality care. The duplicate laboratory test and the hospitalization to perform a diagnosis which is more appropriately office-based will eventually push hospitals to the limits of their resources. Inappropriate care is also inefficient care. It is essential to improve both productivity and appropriateness of care.

If quality care is defined as the most technologically sophisticated care for everyone or the maximum amount of care for everyone, then quality of care and cost containment are in conflict. If, on the other hand, we join forces with business, providers, patients, and payors alike to align our cost containment and quality assurance efforts, we can improve quality and contain costs at the same time. Also, it is very clear that if government continues to arbitrarily and unfairly reduce payments to health providers, the health care system patients currently enjoy will become as obsolete as the Edsel. Furthermore, our hopes of aligning cost containment and quality assurance efforts will be in total jeopardy.

I wish to emphasize the importance of cooperative efforts between providers of health care, particularly physicians and hospitals, and other interested parties. We are engaged in a period of adjustment as we shift from a regulated to a competitive environment. This period will not be without problems, but it also provides an opportunity to develop constructive alternatives to regulation.

If we seize this opportunity, freedom of choice and fee-for-service payment will not suffer in the new health care climate; they will continue to be viable, providing as they do, the potential for appropriate health care at an appropriate cost.

- Mr. Tibbitts, 1423 S. Grand Ave., Los Angeles, CA 90015.

Business and Industry's Role — A Working Partnership with Providers

R. A. Carpenter

Industry's concern about health care is its cost. Health costs continue to rise at an unacceptable rate. There is agreement among my colleagues in industry that our objective is to improve the effectiveness of the use of the money available to provide needed medical care to employees and their dependents. We do not expect to reduce the present level of financing our health benefits programs through transferring costs to other payors, but we envision that through implementation of a variety of health care cost containment initiatives, we can bring the rate of escalation of health costs in line with the rate of inflation of the overall economy without diminishing access to care or quality.

Disregarding the question of whether the \$230 billion, which we are spending on health care as a nation, is or is not enough to spend on health, medical professionals should understand that business is straining its ability to finance more. If we have to contemplate the continued escalation of the \$120 billion paid by business for health insurance premiums and taxes for sick leave, Medicare and Medicaid plus compliance with safety and health regulations, there will be a limitation on business' ability to invest funds into areas needed to improve productivity which would be a serious handicap. Many businesses will not survive and many more will find their financial resources severely taxed unless payors and providers diligently work together to find the answers to controlling rising health care costs.

Competition Legislation

Before identifying the health care initiatives that I believe can improve cost-effectiveness, I want to make some points concerning the so-called "competition legislation" which is very much on the minds of Congress and the Reagan Administration.

The Author

R. A. CARPENTER

Mr. Carpenter is Manager of Health Care Cost Containment for Republic Steel Corp., in Cleveland, Ohio.

There are many factors contributing to health care costs. Major cost escalators have been: improved technology; development of sophisticated medical equipment; inefficient delivery of service; defensive medicine practices; excessive capacity; poor benefit planning and design and overutilization. All of these factors need attention and resolution. The competition proposals address only one cause of high costs—overutilization. Having been concerned about health costs for a number of years and directly involved in initiatives to change the factors contributing to those costs, I believe it is reasonable to question whether the regulation approach will have its intended effect of reducing utilization.

Proponents of the proposals believe that by establishing a tax cap as an incentive for employers to provide lower level benefits and by mandating optional choice plans which require rebate of savings, there will be a motivation for employees not to overinsure or overuse the system. This certainly is a simplification but it emphasizes the main thrust of the competition theories in the proposals.

If the Congress wants to test its various assumptions, it should do so, and I would suggest the Department of Health and Human Services, which controls 40% of our national health care dollars, be allowed to determine the segment of the public sector to be the proving ground.

I urge you not to support unproven theory, but let's grab the opportunity to develop a working partnership on a voluntary basis to prove that the private sector can bring health care costs under control without the need for more regulation. I am confident that the Congress feels that the status quo is no longer an alternative and if we do not demonstrate that we can develop an effective working partnership in a relatively short period of time, it will act and force us to digest more regulation with the potential of making health a public utility.

The Direction of a Working Partnership

There is a line from Lewis Carroll's *Alice's Adventures in Wonderland* which has Alice asking the

Cheshire Cat: "Would you tell me, please, which way I ought to go from here?"

As a nation, we have spent \$230 billion a year for medical care and it is projected that by 1985, it will be \$420 billion and by 1990, \$800 billion. With those costs staring us in the face and with the prospect that the private sector will have to provide a major portion of those dollars, it is very appropriate that we also ask the question, "Would you tell us, please, which way we ought to go from here?"

In a minute I will identify three major directions that I believe are available to us. I do not intend to imply that accomplishing these three objectives will resolve all of our cost dilemma, as there are a multitude of initiatives that need attention, but certainly, if their intent is accomplished, they will go a long way to prove that a voluntary working relationship addressing specific problems can improve cost-effectiveness within the delivery system and impact on the rate of escalation of costs. But first, before discussing these specific directions, allow me to express some thoughts on how we have gotten where we are.

I am confident that this group realizes that finger pointing on the cost responsibility is not productive for any segment of the health care delivery system, least of all if it's done by industry for industry has come to recognize that not all the cost villains have been providers.

The escalating cost of health care benefits agreed to in bargaining contracts of the 50's and 60's has been tremendous. Employers agreed to provide first-dollar coverage, which eliminated any incentive for the employee to be concerned about costs. We agreed to levels of benefits that emphasized confinement in acute care facilities with a disincentive for ambulatory or outpatient care. We acceded to the pressure of the unions and the recommendations of our carriers and consultants to accept prevailing fee and usual, customary and reasonable reimbursement mechanisms which have been major cost escalators.

Industry has to share the responsibility for our present condition. In the past, we have been a passive payor; however, we now have a problem and timely action is needed. And actions taken solely by business and industry without the participation and support of medical professionals will not prove successful in my opinion. We must have a working partnership, and that cannot be overemphasized.

What can such a partnership accomplish? As indicated above, there are three major directions in which we should go that can result in meaningful and cost-effective accomplishment both on a national and local level. They are: the establishment of coalitions; the development of area planning strategies; and the implementation of utilization review mechanisms.

Coalitions

I believe that concerns about health care costs can best be addressed through community action or coalition-type groups. Each geographical area has different needs and problems. Each community, therefore, must make a concerted effort to identify where the need for change exists, and establish priorities which will provide them the opportunity to address a manageable workload of initiatives. I am convinced that such action groups that involve all segments of the system offer the greatest potential. Employer, provider, carrier, labor, academia and consumer are those segments that will best be able to address specific issues and resolve mutual concerns—as a working partnership.

The Greater Cleveland Coalition on Health Care Cost-Effectiveness, of which I am a co-founder and director, is one of more than 60 coalitions in the country and is an example of how all the segments of the system are working together to identify and resolve the problems. We have established task groups to address the highest priority of our members' concerns, which are: the establishment of a database to pinpoint the abnormal patterns of practice; the regionalization of services to eliminate duplication, where appropriate; education for hospital trustees and education of employees to help them be better purchasers of health care. The coalition has been responsible for the development of mutual respect between all its partners and has provided the forum for initiating cost-effective programs.

The South Florida Health-Action Coalition is unique in that your Governor was involved in its formation and actively participates in its efforts. Although all segments are not directly represented, the Coalition's Board of Trustees in its "work plan" supports the enlistment of input from medical professionals.

The American Medical Association has initiated community action forums and is to be commended for its efforts in getting over 25 state and county medical societies to join hands with employers, labor and carriers in addressing a broad range of health cost issues. I believe employers accept such action as evidence of the willingness of a broad segment of providers to be working partners in the effort to find cost solutions.

I believe all coalitions, regardless of their constituents, are going in the right direction. They are concerned about rising costs which cannot be left unchecked and they are anxious to determine what are practical alternatives. Coalitions have been the catalyst which have brought together employers and providers working to resolve mutual concerns.

Health Planning

A specific concern of coalitions is health planning

and this is the second direction that I encourage you to support.

The thrust of the Reagan Administration is away from regulation and toward the opportunity of the private sector to assume responsibility for its own destiny. Employers are generally in agreement that the funds from the federal budget for local health planning should be eliminated, not because health planning has proven to be defective, but because each community should have the opportunity to determine what planning functions it needs and how it will choose to support those functions, specifically as to the human and financial resources needed. It is of interest to employers in Ohio that our Governor has convinced Secretary Schweiker of the Department of Health and Human Services, that health planning in Ohio has been "arbitrary, capricious, and politically motivated", when, in fact, the Metropolitan Health Planning Corporation, which is Cleveland's Health Systems Agency, has a track record that shows that from 1976 through September of 1981, it disapproved \$200 million in requests because they were determined to be unnecessary. However, of this \$200 million, seven recommendations were overturned by the State Planning Agency, reducing a real cost savings to Cleveland by \$100 million.

It is also interesting that the President of Blue Cross of Northeast Ohio has indicated, in an article in *The Cleveland Plain Dealer*, that "we provided the financial incentive enabling a 144-bed hospital in Cleveland to close for good, thereby saving our subscribers an estimated \$2 million annually, but we cannot win this fight as long as the State keeps overruling both (ourselves) and the local planning agency whenever we vote against hospital expansion and other capital expenditures, which we and the agency deem unnecessary . . . For example, during the last 18 months, Blue Cross has opposed requests for 1,066 additional hospital beds . . . The State approved all of them." With this record of State action, I think I agree with the Governor. Planning in Ohio has been "politically motivated".

At the present time, the Greater Cleveland area can expect capital projects of approximately \$800 million to come off the drawing boards when planning funding and legislation are terminated. Estimated capital expenditures for development of medical facilities in the State of Ohio are projected at \$2 billion. Ohio employers are concerned. If capital expenditures of this magnitude are allowed to further proliferate what are already excessive services, the private sector will only have itself to blame for the attendant costs. Planning is a local issue. There must be time, however, for local planning strategies, supported with human and dollar resources, to replace that which is being taken away. This cannot be done in a short period of time. There must be a breathing spell for

these mechanisms to be identified and established within our communities.

I continually say to all medical professionals that if you are interested in being a working partner, then you will join business and industry in their efforts to have some constraints put on capital expenditures by supporting strategies that establish planning requirements on a community-based agenda. Again, I believe that employers will and are able to address the needs of health planning. In addition, they will be willing to offer financial resources for funding of such strategies and will provide the human resources to enable them to be participants in finding solutions to our planning needs, but your participation and support is needed.

Utilization Review

The third direction of our working partnership should be the establishment of utilization review mechanisms that allow identification of abnormal medical practice patterns.

When employers have reviewed their hospital claims, doubts often are raised as to the appropriateness of some of the services rendered for the reported diagnosis. Employers want their employees and dependents to have access to quality care — when needed and, in addition, are willing to have medical professionals call the shots. But when they see hospital confinements for procedures and services which could be performed on an ambulatory basis, or might not have been needed at all, they ask questions; and more than once have been told, "the utilization review committee felt that the services were appropriate". More than once they have been told, "discuss the problem with the physician; he's the one who orders the medical care". More than once they have been told, "we provided the service—you pay the bill". This year, Republic Steel Corporation will pay the bill to the tune of about \$57 million for hospital services. That will be approximately 16 per cent higher than last year. My colleagues in industry are facing the same rate of medical cost inflation and they are recognizing the need to implement private sector utilization review mechanisms to identify the outliers, be it a hospital or physician and, thereafter, to insist upon discussion with the professionals to bring about elimination of inappropriate care. Industry has a growing support for utilization review programs which use levels of care criteria established by physicians and has medical review administered by physicians.

"Governance" Corporation

In Cleveland, we are developing a private sector utilization review program which has the written support of 24 leading employers. The review process is planned to be through the local Professional Standards Review

Organization contracting with a "governance corporation" which will administer the program, including contracting with hospitals and employers. The "governance corporation" concept, as proposed, will have a 12-person Board of Directors, made up of representation from the Academy of Medicine, the Hospital Association, insurance carriers and employers. The review process is projected for 100 per cent concurrent review of admissions and length of stays. Review of the medical necessity of the admissions and length of stays will be performed in the same manner as that of federal patients. All private sector admissions will be subject to review within 24 hours. Concurrent review will be conducted cyclically, using established levels of care criteria and questionable cases will be referred to a physician advisor for medical necessity determination. Adverse determinations will be processed according to the same guidelines used for federal review, except that adverse determinations will not be mandatory for the hospital or patient until the employer and/or insurance carrier so approve. Notification to the patient of the adverse determination is expected to be from the employer or insurance carrier.

We hope to have this system in place by the spring of this year as a result of the support from the Greater Cleveland Hospital Association and some of its members, and the Academy of Medicine. The formation of this program has taken almost two years, but we are optimistic that we will have a mechanism which will accomplish its purpose and a working partnership with providers for its administration.

A similar project has been underway in Chicago. I have been actively involved as one of three employer

representatives in this effort and we are pushing forward with the Chicago Medical Society and the Chicago Hospital Association to establish a private sector concurrent utilization review process for Cook County.

It is evident that industry is supporting utilization review which has high standards of appropriateness and quality as established by medical professionals and which embraces mechanisms that have a proven track record, such as the John Deere, Caterpillar and Motorola programs. If employers are not involved in utilization review, I urge them to get involved.

Conclusion

In conclusion, I strongly recommend to employers that they encourage hospitals and physicians—all providers—to work with them to support the development of increased cost-effectiveness in the delivery of needed medical care and to embrace initiatives intended to put a brake on the rate of escalation of health costs. The highest priorities to accomplish this goal are through the establishment of community-action coalitions; in the development of local health planning strategies and the implementation of those strategies with the support of human and dollar resources from the private sector; and putting in place utilization review mechanisms that can improve the appropriateness and quality of medical care.

Unlike Alice, I recognize the direction in which we must go—and it is very clear that we must travel the road together.

- Mr. Carpenter, P.O. Box 67778 Republic Building—Suite 1507 Cleveland, OH

The Patient's Role in Health Care Financing and Delivery

Bess Myerson

I appreciate the opportunity to be with you this morning—because I share the concerns of your conference, and also because I believe the questions you are raising and the answers you are seeking are the most important challenges facing us not only today but for all of this most difficult decade of the 1980s. The '80s will be a crossroads decade for our country, in which our will and our capacity to find our balance again will be tested as perhaps never before in our history.

I believe that your agenda goes far beyond the problems of one profession, and reaches out to touch the dreams of every American family, wherever they live and work and plan a better future, because the health of our people is the foundation on which everything best about us must be built—the health of our national economy, the health of our national security, the health of our democratic spirit, our healthy and confident stride toward whatever tomorrow may bring. You are the custodians of the real energy source that keeps the promise of our country alive and well; we can do anything—as long as we're healthy.

The health care professions are the strong stitches that hold together the economic and social fabric, and it is only when we permit those strong stitches to unravel that important parts of the fabric begin to fall apart. Narrow confrontation nudges aside broad cooperation, self-interest pre-empts public interest; health care becomes a political, ideological, economic football, with everybody fumbling and losing ground; and those who should be closest to each other in purpose seem to have lost sight of each other, and of the purpose.

We Need Each Other

For you and for consumers, that closeness and sharing of purpose must never be disrupted. We need each other—we literally cannot live without each other—

The Author

BESS MYERSON

Miss Myerson, a former Miss America, was New York City's first Commissioner of Consumer Affairs.

and any obstacle placed between us, by ourselves or by anybody, which transforms health care from a basic need reasonably met to a luxury item beyond the financial reach of many, is both a cynical abuse of your profession's unmatched capacity to protect and heal, and an unconscionable theft from consumers of the knowledge, skills and leadership with which you can serve our well-being.

Some obstacles are between consumers and doctors now. No matter who placed them there, we must remove them with shared efforts that are mutually advantageous, because any gain that is made only at the unfair expense of the other is no gain at all. Your professional health and our personal health should be inseparable. Despite responsible measures taken to close whatever communication gaps exist—and the Florida Medical Association is exceptional in that effort, with your pamphlets, medical messages, and state and local projects—when many consumers look at health care today, they suffer from double-vision. They are deeply respectful and appreciative of what you have already done, achievements unmatched by any other nation in the world, but they are also nervous and discontented about what inexplicably remains undone.

Doctor Patient Relationship

They are almost reverent about the best traditions of the doctor-patient relationship and, by extension, the relationship with every facet of health care; but they are also frustrated, wondering whatever happened to those traditions, many of which cannot be seen today with the naked eye. They celebrate with pride your skills and dedication, your research breakthroughs, your technological advances, your high standards of service, but their pride is undermined by puzzlement of why too often there remains a gap between what you know and what they get, between development and delivery, between the glow of the promise and the receding light of access to performance.

Consumers have learned from their experiences in the marketplace that too many thrusting their products and services at them seem to have no sense of

responsibility beyond a hidden credo of "take the money and run". But they don't see you as just "another part of the marketplace". Despite the grumbling you may hear, sometimes rising to a shrill protest, you should know that your profession retains a strong hold on the imagination and trust of most consumers. You and what you do are special to them, and you would be even more special if you could move closer to them, lower the walls that professional expertise sometimes builds around itself.

I think if that common-sense relationship can be restored, the dollar-and-cents burden which afflict both doctors and consumers will begin to be more solvable, no matter how deeply any self-serving obstacles are dug in.

More Accessible and Less Costly Health

If we are to find the right road ahead to better health care, more accessible and less costly, we must take a quick look backwards to rediscover the old road from which we have strayed. That was the road on which the old traditions of the doctor-patient relationship flourished, with a sense of intimacy, mutual understanding and respect, common purpose, and neighborly concern. Somewhere along the line, the small intimacies lost out to the big business that health care became. Only the oldest consumers among us can remember what a "family doctor" looked like, or what a "house call" was.

We may have had to sacrifice the form of that uniquely personal service, but we should never lose the spirit of it. Because that is the spirit in which the initiative of the individual consumer is stirred, and the opportunity of your profession not only to treat but to teach, and to lead, is at its greatest. And the power to communicate each other's needs, especially where they coincide, as in the emphasis on preventive medicine and lowered costs, is at its strongest and most effective.

What you want and need for yourselves, and what consumers want and need for themselves, begins with that alliance of interests. It's a shared strength that neither of us can afford to waste, a shared strength that can be found in no other part of the marketplace. It can cut through government short-sightedness; it can provide the initiative to eliminate waste in health care programs; and it can educate and inform consumers of their own wasteful contributions to higher costs and neglected care.

A Look Backwards

While I looked ahead to all the complex problems that fill your agenda today, I also took my own look backwards. When I was growing up in The Bronx I lived in a neighborhood where trouble was a permanent resident. Whatever could happen to man, woman or child, happened there. People lost their homes; people lost their children; people lost their jobs; and some just lost their way. But no matter how much debt, sadness,

pain, or confusion, there was always somebody around who had the rock-bottom answer: "Well" they would say, "as long as you've got your health!"

The country seemed to be falling apart then, but that was the ultimate strength, and hope. Health was the family fortune. As long as you held on to it, anything and everything was possible; without it, life was an even more difficult obstacle race. Health was a possession not to be wasted, our blue-chip investment in the future; and those who helped us to keep it won our respect, gratitude, and confidence.

Our doctor was like a member of our extended family. A visit to the dentist wasn't the most pleasing experience, but we were taught that the man behind that fearsome drill was there to help, not hurt us. Our druggist on the corner was also known as "doctor" to us; he would get up in the middle of the night if we had a family emergency and also kick us out of his store if we tried to buy too many sweets, even though the dentist was his brother-in-law. Every nurse was Florence Nightingale to us. School dietitians, gym teachers, camp counselors—all seemed to take a special interest in keeping us healthy, maybe because they came from the same background, where illness to any member of the family could put the family budget flat on its back for years.

That's the way I remember it, and that's the way I think most families and neighborhoods remember it. Health was a passport to opportunity and to a better future.

Times have changed, of course, but I do not think the hopes and fears of families have changed. That is why consumers today look at you, and to you, differently than we do at others who sell or provide services to us.

The Sense of Intimacy

Behind any changes or confusions that surface as health care has moved from the easy familiarity of the old neighborhood to the impersonal efficiency of big business growing bigger, there is still a sense of intimacy with you. That can be your greatest asset in reaching out to consumers, if you are wise enough to nurture it.

You are with us when we are at our most vulnerable. You help us meet our deepest fears. You are not the purchase of a toaster to us, or a trade-in for a new car, or a ticket to a hit show; you are more personal to us than anything we may do as consumers. Our relationship with you is a cash-for-services transaction, of course, but it always has been and always will be, more than that.

That is why the trust, confidence and understanding between us; the shared awareness that higher costs can ruin us both; and the shared effort to bring down those costs, must be restored wherever it has eroded, and for whatever reason. Your state medical association is

exceptional in developing cost-cutting programs in every area of health care. I was heartened by reading your literature, and from conversations here to learn of the great support those efforts are receiving from members within the association, and from consumers. Other state medical associations also have mounted effective cost-cutting and consumer information programs, and practical campaigns to enlist the active support of everyone who must be involved if lower costs and higher quality of services are to be achieved, from neighborhood health facilities to legislators in state and city bodies.

Waste and Inefficiency

But even in the states where that initiative has been taken (and in many states it has not been taken to any appreciable degree) there are problems of waste and inefficiency of delivery that are beyond the capacity of any one state to resolve by itself. The heart of the problems are in our national attitude; the response must be a national effort, by both the entire health care community and by all consumers who are victimized wherever stratospheric costs or any inequities threaten to close them off from the care and treatment that you want to bring to them, and that they desperately need.

The response must be now, when everyone on every economic level, especially our middle-income level, is caught between inflation and cutbacks of essential service programs. The middle-income families, which must always pay-as-they-go, have gone about as far as they can go, and their health care problems must be given immediate and greater attention.

Last year, the cost of medical care rose 12.5 per cent, the largest annual increase since the government began keeping records on medical costs in 1935:

The cost of hospital rooms—up 17 per cent;

The cost of doctors' services—up 11.7 per cent;

The cost of dental services—up 10.2 per cent;

The cost of prescription drugs—up 12.6 per cent;

and

The cost of non-prescription drugs—up 10.3 per cent.

There is no lack of reasons for the spiraling costs—inflation, labor, capital budgets, waste—but at the end of anybody's list of reasons there is always the same bottom line: higher, often outrageously higher bills. The statistics are frightening enough even in cold print, but every day you are the people who see the flesh and blood of those statistics, and the bewilderment, and the fear.

If we do not step up our combined effort to bring down costs, it could be a terminal case of complacency for both consumers and the health care professions.

Initiative Blunted

With some consumers, individual initiative seems to have been blunted by a euphoric feeling that everything

has been taken care of through various private and government plans, and a patient may be tempted to seek "over-treatment" — every test and service on the menu, whether needed or not, because (he thinks) somebody else is picking up the tab.

Even the most deluded consumer is now getting a crash course on who pays the bills for health care, whether through increased insurance payments, increased taxes, the sudden discovery by people in need that they are not considered truly in need and thus denied assistance that is vital to them, and also through higher prices for the products of companies who pay an increasing part of the health costs of their employees.

But if there is any lingering complacency among consumers, it may be that their complacency is helped along by a companion complacency within the health care professions themselves, by those who get along by going along, and collect handsomely as they go. Consumer initiative in health care depends upon an understanding of why that initiative must be taken, how costs can be brought down, and how quality can be improved. No one can teach and guide the consumer toward that understanding better than the doctors.

That teaching and that emergence of the doctor from the office and into the neighborhood is in the oldest and best tradition of your profession. In my reading, I came across this precept of Hippocrates (Chapter 6, if you want to look it up):

For where there is love of man, there is also love of the art. For some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician. And it is well to superintend the sick to make them well, to care for the healthy to keep them well, also to care for one's self, so as to observe what is seemly.

To make them well . . .

To keep them well . . .

To observe what is seemly . . .

The prescription for lower costs, for preventive medicine, for a healthier community, and for the mutual trust and support is in that precept.

Speak as One

On everything that makes us well and keeps us well, and especially on the preventive measures which can reduce our illnesses to a minimum, the voices of both doctors and consumers must speak as one in support of each other. They must speak as one not only in eliminating costly waste in hospital bills and insurance plans, where positive recommendations have already been made separately by your profession and by consumer groups, but also in those areas where one side has been totally silent, perhaps because it did not think it a shared issue.

Consumers have failed for example, to appreciate fully and share the concern of doctors over skyrocketing insurance costs to protect themselves against the epidemic of malpractice suits which too often are frivolous or beyond reason. Aside from the fact that every item of a doctor's overhead eventually finds its way to the patients' bills, it has also led to the practice of extensive and seemingly endless diagnostic tests, more for the protection of the doctor against lawsuits than for the protection of the patient against illness. The result: higher costs. The doctors' fight against exorbitant insurance should be the consumers' fight, also.

The deregulation blitz now taking place against agencies concerned with consumer protection must also be opposed by everyone, consumers and doctors, who want to keep down health care costs. Just as over-regulation can be harmful and costly, under-regulation can be equally dangerous and expensive. If the standards of the Food and Drug Administration are relaxed beyond effectiveness, how do you measure that in future health costs? If the standards of the Consumer Product Safety Commission are weakened to the point where "safety" is just a word in the title, how do you measure that in future doctors' bills? If the clean air or auto emission or product disclosure rules are thrown out, how many walking wounded will you be treating in the months and years ahead?

Here's another scary statistic to ponder. In the year of the great deregulation blitz, in the Food and Drug Administration alone, enforcement of regulations declined 45 per cent, according to a national consumer research project.

If the budget-cutters look upon nutritional standards and nutritional information programs as expendable, how much in future costs will that add to our medical bills? Let me quote some figures with which you are familiar, because you distributed them in one of your publications, "Cost of Medical Care".

Cost of Losing Weight

In one year, 79 million overweight Americans spent approximately \$10 billion dollars to lose weight. Much of

this was spent on fad diets which have their own built-in medical dangers. The leading six causes of death are dietary related.

You also had some interesting figures on tobacco and alcohol.

Illnesses related to smoking account for 1 out of every 12 dollars spent on direct health care costs and more than 9 million alcoholics cost our country over \$44 billion in medical bills. Nevertheless, we subsidize our tobacco growers, and curtail our alcoholic rehabilitation programs, and the national voice of the medical profession is hardly heard on this health issue—or on those of clean air, auto emissions, plant safety, or most of the issues that are being dismissed as "consumer" extravagances, when they are really the most basic of "health" issues.

Health As a Personal Matter

Health is a personal matter for every consumer. Awareness of health care needs and action on health care costs must begin in each individual, if it is to begin at all, but consumers need your active help to define their own concerns. Without your broadest support, consumers may take their own steps forward in their own interests, but they will be smaller steps than they could take with you. It's a wise consumer who knows that and moves closer toward your skill and dedication and knowledgeable leadership.

It is also a wise doctor who knows that, and moves closer to his patients' needs, not only in the hospital or in the doctor's office, but also in the community and place of work and everywhere else. Our good health is on the line.

"As long as we've got our health" should be our duet, in the old tradition. Then, come what may in this question-mark decade, our future will be healthy and bright.

And our health costs lower.

- Miss Myerson, 3 East 71st Street, New York, NY 10027.

The Public's View of Health Care Delivery and Financing

Roy A. Pfautch

In a nationwide sampling of physicians taken in November, 1981, a strong majority indicated that the problems facing medicine are basically problems caused by government interference with medical practice. Nearly 60 per cent of these physicians believe that doctors are losing the fight to control their own destiny, because that destiny is now shaped by non-medical government bureaucrats.

In a 1976 sampling of physicians in Maryland, Minnesota and Nebraska, physicians overwhelmingly indicated that the continuing encroachment of government into the private practice of medicine is the number one problem facing physicians. A similar sentiment was found in a survey conducted among Florida physicians in 1975. An update on the nationwide sampling in November, 1981¹ again indicated that a strong majority of physicians believe that government continues to be the major concern, outranking cost containment, the malpractice crisis, etc. These comments set the stage for our review of public attitudes on health care. They illustrate that today the physician must be very much aware of public feeling because public feeling is a direct pressure on government.

A Major Dichotomy

In examining public opinion on the whole range of health issues, we immediately note a major dichotomy: the difference between public attitudes toward the physician as a personal entity and public attitudes on health care as an institutional reality. Further, among the latter category, we must recognize another dichotomy which is the attitude toward the quality or miracle of health achievements versus attitudes toward health care delivery and the availability of the same quality.

First, let us look at attitudes among the public, which indicate both opinion toward health care in general and

then specific concerns within the field. Above all, cost is the major problem present in the public mind when asked questions about health care. For example, when asked what they believe to be the main problem, in a August, 1981, Gallup nationwide survey of 1,564 voting age Americans, 55 per cent mentioned cost. It should be noticed, however, that this is a decline from 65 per cent who mentioned cost in a 1979 Gallup survey. This finding is borne out by similar results in other nationwide surveys. The next highest response was 12 per cent citing the quality of health care, followed by 6 per cent distribution.

It is interesting, however, that only 8 per cent mentioned the high cost of doctors and doctors' raising their fee, as a first concern of health care. This is also down from a 1978 Gallup survey in which 13 per cent were concerned about doctors' costs.

The point is made here that the high cost of medical care is not necessarily related in the public mind to doctors' fees. This is an important emphasis which needs to be developed in public comment about the total health care picture. It also speaks to the point that doctors should not be intentionally paranoid over talk of the cost of health care in terms of presuming that public concern about costs means negative concern about doctors. While there is a need for public exposition on the cost of health care, it is equally clear that there is a need for a definition of the physician role within the total health cost picture.

Attitudes Toward Quality

Overall, public attitudes towards the quality of health care in the United States remain very high; nevertheless, it should be noticed that there has been a slight but steady increase in the percentage who mention quality as a problem with health. This percentage has grown from 7 per cent in 1977 to 14 per cent in 1981. Of this 14 per cent, 3 per cent are concerned about the adequate delivery; 2 per cent with incompetent doctors; 2 per cent with unnecessary medicine; 2 per cent that doctors are too hurried; and 2 per cent with the doctor-

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patient relationship. Selected statewide surveys indicate a basic majority believe we have the highest possible standard of health care; however, the majority is slim and communication is needed to bolster the public's regard of the system.

In the 1981 Gallup survey there were several findings dealing with ability to pay for health care. Nearly two-thirds were fairly confident in their ability to pay for their usual medical cost. Half were sure they had enough insurance coverage or money to pay for a major or extended illness. As might be expected, the percentages on these two points relate strongly to the socio-economic status of respondents, with a decline in competence to pay as one moves down the socio-economic ladder.

Continuing the strain of satisfaction with the quality of care, 90 per cent were fairly satisfied or very satisfied with their last visit to the doctor, including a 58 per cent very satisfied. Satisfaction with the quality of health care in the United States is also reflected in the 1981 Gallup National Poll, indicating that respondents are not receptive to change in the system. Only 6 per cent indicated they would be willing to wait longer for non-emergency hospitalization; and 19 per cent would be willing to wait longer for an appointment. Only 39 per cent said they would be willing to be treated by one of a group of doctors rather than having a personal doctor.

Trained Assistant

Surprisingly, 49 per cent approved of the statement that for certain problems they would see a trained assistant rather than a doctor; 48 percent disapproved of this. The percentage approving the seeing of a group rather than a personal doctor has risen 4 per cent in 1979; but, in terms of 1977, it is 2 per cent less than was noted from the Gallup survey of that year. The Gallup survey indicated that nearly half of the respondents feel there are the right number of doctors in their communities. However, nearly 38 per cent felt there were too few; and only 10 per cent said there were too many.

Finally, in terms of the public attitudes toward government activity in the health market place, it is interesting that more than half of all respondents (58 per cent) believe health costs are higher because of government regulation of medicine. This is a 9 per cent increase in sentiment in the last two years. However, respondents believed the quality of health care would decline if there were less government regulation. Forty-three per cent said the quality would decline versus 22 per cent who said it would improve.

In summary on this point, 50 per cent felt that the good in government regulation outweighs the bad; whereas, 29 per cent believed the opposite.

Survey after survey has identified the physician as one of the most highly regarded members of today's American society. Accompanying data in such surveys indicate less regard for the institution of the physician, but the strength of the personal physician was attested to in the 1975 survey of Florida physicians, in which physicians and clergy were by far the most highly regarded members of society. Doctors were cited by almost 30 per cent of the sample; clergy, by 23 per cent. In a Missouri sampling in 1978, physicians were named by 28 per cent and clergy by 33 per cent. There is a considerable gap between second and third place.

Confidence Remains High

Other soundings periodically indicate confidence in the physician remains high. This is an important foundation on which to build public confidence in the physician's role in the direction of overall health care policy. Despite all of the public controversy of recent decades as to the nature of the health care system in the United States, the public remains loyal to the competence of the American physician. On this confidence, the role of the physician for the future should be built and expanded.

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Health Care Financing — The 1980s

Stephen A. Doiron

Newspapers throughout Florida are reporting a determined revolution underway in the state. Employers are forming coalitions to combat the rapidly increasing cost of health care. Rate increases over the last six years alone exceeded 140%, and the coalitions are planning a common strategy to combat what they see as excessive costs.

Employer coalitions in other parts of the country have already begun taking action to contain costs. Many of these employer groups have financed Health Maintenance Organizations, taken over health planning functions for the community and negotiated severe restrictions on insurance carriers who do not implement effective cost containment procedures.

In terms of health care financing, the effects of 1981 were disastrous. Total costs escalated at a record high rate of 20%; federal programs were cut or grouped into block grants and turned over to the states; states began a frantic search for solvency in their Medicaid programs and insurers announced premium hikes as high as 50%. Many hospitals were forced to scramble just to cut their losses and remain afloat; more employers turned to self-insurance; and the Administration declared its intention to promote more competition.

At the dawn of 1982 we are all beginning to experience, and hopefully understand, what all the yelling is about. The Administration plans further budget cuts; a pro-competition bill and a proposal to eventually take over Medicaid. The Congress plans to keep looking the other way until the election is over.

Since that point in the early 1970's when medical costs ended their long period of tranquil upward movement, most of the planners and managers have been unable to regain control. The time tested tools and tactics, so effective in earlier times, now seem useless against the momentum and pressures at work.

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Where Are We Now?

Most managers of health care financing probably would describe the component parts of the health care system as follows.

I. The Physician

The increase in medical school capacity, stimulated by state and federal government, has led to a sharp increase in the number of physicians, a major factor contributing to an increase in utilization of medical services and thus, the cost of health care. More dramatic increases in physician supply are expected in the next ten years. Many areas already are experiencing a surplus of physicians, which is forcing physicians into intense competition for patients.

II. The Hospital

Hospitals account for more than 40% of every health care dollar, the largest single component in health care costs. The increase in hospital cost has been compounded by the high cost of money over the last five years. As a function of the economy and demographics, hospitals were scheduled to begin refinancing their capital debt during the decade beginning 1980. New facilities built at great cost have attracted more utilization, all at higher prices.

III. Technology

Technology grew at a faster pace in the 1970s than ever before. New technology created its own demand for application and at a very high cost, financed at higher rates of interest, helped boost the cost of health care even though technological improvements reduced the unit cost of delivering care.

IV. Insurance

The traditional financiers of health care (for this discussion I include Blue Cross and Blue Shield) became caught up in the fast flowing river of cash in the 1970s. They felt little pressure to increase their efficiency of operation. Formulas for computing rates and tracking losses were not modernized or tested for reality. Individuals covered by health insurance policies felt little of the upward pressure since most of the cost was carried by the employer and was not taxed as income. Since there was no direct involvement in the payment for health care financing, the increases went unnoticed. The

insurance industry is convinced that it will have at least as bad a year in 1982 as in 1981. Insurance companies have been raising their premiums for most of their larger plans by a factor of 12 to 18 per cent per year. Rates for smaller plans have been rising by more than 25 per cent. This has occurred during a period when the rate of inflation has dropped below 10 per cent for the first time in years. In an effort to combat these increases, employers have been shifting their financing to low premium Stop Loss or Administration Only (ASO) contracts with insurers. The reduction in premiums paid to insurers will further increase the premiums paid by remaining employers should all other factors remain equal.

V. Health Maintenance Organizations

Less than 5 per cent of the population is covered by these HMO plans, but the number is growing rapidly each year. As many as 25,000,000 people may be covered by HMO's by 1990. Insurance companies have become increasingly involved with HMO's during the last two or three years. Blue Cross companies manage over 40 HMO's with over \$100 million invested and other companies such as INA, Prudential and Waussau Insurance have major commitments in HMO development. They see in the HMO an opportunity for the third party administrator to become involved in cost containment as well as creating a complimentary product line. There are over 150 HMO's in operation today, many of them in California. Minneapolis, Boston and Washington, D.C. have HMO's with more than 100,000 members each, but most HMO's have smaller enrollments. The Kaiser Permanente Health Plans cover more than 4,000,000 persons. Current projections indicate that as many as 750 HMO's will be in operation by 1990. Most will be built on the Independent Physician Association (IPA) model. Due in large part to their lower capitalization requirements, IPA's also offer an immediate physician dispersal pattern throughout the HMO marketing area.

IPA's, on the average, require about \$1.5 million investment capital to reach their break-even point. This sum is substantially less than the \$4.1 million required for Group or Staff models, which require more expenditure in site facilities and equipment and which are much more labor intensive prior to reaching their breakeven point. The IPA takes advantage of the capitalized worth of existing physician's facilities, staff and equipment by not having to pay for these until the demand has been made and fulfilled. An IPA/HMO can conveniently adjust to changes in population since most of their member physicians will have moved their offices to take advantage of those changes.

VI. The Public

The cost of employer-sponsored health care on plans is added to the cost of doing business. As a percentage of payroll, 5.8% is paid by the employer and

1.2% is paid by the employee. Approximately 67% of all Americans have their health care financed in this manner.

Future Outlook

The rewards for creating solutions to health care financing problems will be great. IPA/HMO development offers the most promising opportunity for physicians, employers, insurance companies and consumers to join in creating a new and profitable system for health care. On a regional basis, large employers are financing HMO's in an effort to have more of a voice in cost matters. Employer coalitions are finding that a combined effort to finance HMO's can provide long term benefits by lowering their direct costs. Some physician effort has been noted, but it generally is poorly motivated, and commitment from the medical community as a whole is lacking. Most professionals have operated outside the financing arena and are finding it difficult to become philosophically involved. In fact, the most logical financier of health care is the physician/provider sector. Bypassing the middleman and the attendant costs, we would also experience an increase in the efficiency of health care financing.

IPA's are a business and offer attractive financial incentives. As an investor, the physician is uniquely capable of evaluating the performance as well as advising management. The increase in the number of HMO's over the next decade, the willingness on the part of employers to participate in alternatives for health care financing, the vacuum being created by the departure of many health insurance companies, together with the government's movement away from National Health Insurance augers well for a renewed emphasis on private initiative and the IPA concept.

What then is the IPA concept?

In 1721, a physician in Boston offered his patients the option of paying him on a fee-for-service basis or "five pounds per year sick or well", and as early as the 1930's, physicians were beginning to form associations to provide pre-paid services for their patients. In the Pacific Northwest, employers joined with physicians to form prepaid plans covering a wide geographical area. From these plans grew the Blue Cross and Blue Shield concept. Today, many employers are seeking to renew this cooperative spirit to answer the increasing cost of health care.

Individual Practice Association

An Individual Practice Association (IPA) is a form of HMO. The term HMO usually implies a Group or Staff model. Staff models operate with an employed staff of physicians practicing at a specific site with a well defined

role within the operation of the HMO. A Group model tends to operate on the basis where the HMO pays a per capita or "capitation" fee to a physician group practice arrangement. Group models may have several Group sites depending on the number of groups required by the HMO. In this case the model is called a Group Network.

The IPA has as its main point of departure the fact that the physician remains a private practitioner in his or her own office, continuing to practice for both HMO subscribers and private pay patients. In all cases the subscriber contracts with an HMO to receive a stated list of comprehensive health care services for a flat monthly fee. Some HMO's offer these services for no additional fees, while others require an incidental fee at each point of entry into the health care system. The collection of a fee does not alter the definition of the system as an HMO, rather it is an outgrowth of its rating formula.

In an IPA model, the HMO contracts with physicians who have formed a legal corporation to provide services to the subscriber. It is membership in this corporation that identifies the physician as an HMO physician. The IPA physician bills the IPA for his services on a fee-for-service basis. Embodied in the IPA contract are the procedures for renegotiation and review of the contract on a regular basis.

IPA—"Open Panel"

Most IPA's operate on an "open panel" basis and do not seek to limit entry into the IPA by physicians who wish to participate. IPA's will include entire group settings as members of the IPA but will not have as members those on staff as employees. The IPA does not concern itself with the day-to-day running of the HMO operations. Other than as a contractor to the HMO it does not concern itself with the marketing design or subscriber membership of the HMO.

The IPA does not usually concern itself with the contracting by the HMO for services provided by hospitals, long term care facilities, ambulance companies or nursing staff. It is primarily concerned with the benefit design, adequacy of premium revenue, availability of medical care, peer review, qualification review and the design of the physician incentive/risk factor. IPA's are governed by the membership who elect a board of directors.

Membership in an IPA is carried out through an application process similar to that of a hospital medical staff. A Credentials Committee, composed of members of the IPA, reviews the qualifications of the applicant and determines whether the applicant's style of practice is compatible with the goals of the HMO. Patients are treated by the HMO physician in his normal practice setting. If there is a nominal sum to be collected at the time of patient visit, it is usually retained by the physician as part of his fee.

It is important to understand that the fee-for-service contract with the IPA is the fee usually charged as an average by all member physicians of that specialty.

Appropriate Fee For Service

The decision as to the appropriate fee-for-service is derived from the following sequence:

The IPA has its physician members submit their usual fee-for-service schedule to a committee formed for schedule construction. The average for all schedules is calculated and this becomes the contracted fee-for-service schedule until renegotiation occurs. Most IPA's do not publish this maximum fee but will advise members who do exceed it to resubmit their fees.

Members who consistently exceed the maximum fee may not be invited to renew their membership in the IPA. Another element in the IPA revenue process is known as the "physician incentive/risk factor." Since the HMO has contracted with the subscriber for a flat fee for all services covered under the contract, the HMO calculated that fee on an actuarial assumption of the anticipated utilization of those services. Since the fee-for-service element is known, and the revenue for coverage is known, the only variable in the equation is the increase or decrease from the assumed utilization.

The HMO pays the IPA, on a monthly basis, that portion of the assumed medical costs for physicians. The IPA, in paying the physician under the fee-for-service contract, completes the payment cycle and no further fees may be billed to the patient. Costs for the services required by the members of the HMO may exceed the capitation payment received by the IPA, placing the IPA financially at risk for the excess fees. To guard against this, the IPA typically holds back a percentage of the fees to be paid to form a pooled reserve.

At the end of each year most IPA's divide any surplus in the pool among the members of the IPA. Some IPA's may retain the pool into the following year choosing instead to reduce the hold back for that year. In any event the risk pool forms an incentive to physicians to control those medical costs that derive as a result of the physicians' part in the health care delivery system.

Utilization and Quality Review

The IPA maintains sole responsibility for both utilization review and quality review procedures. Member physicians determine the standards of health care delivery and entrust the monitoring of those standards to a full-time staff, which is usually headed by a Medical Director assisted by a medical coordinator (RN) and a claims analyst who seeks to determine whether or not the level of health care meets the membership developed criteria. Any deviations are forwarded to the

medical coordinator for resolution with the individual physician.

Any differences which can not be resolved with the medical coordinator are forwarded to the Medical Director for consultation and binding resolution by the peer review committee. It is important to note that the process described is physician designed, physician monitored and subject only to peer review. In addition to monitoring health care, the IPA also monitors the utilization of medical services.

In the case of utilization review, the most common target is hospitalization. Prior to admission the physician contacts the medical coordinator. The IPA will then verify that the subscriber is eligible for benefits and, according to the diagnosis, what the length of stay should be. It is important to reiterate that all criteria available to the medical coordinator are developed by the IPA physicians and are subject to revision when, in the opinion of a majority of the members, new criteria need to be developed. If additional days of hospitalization are required, the physician requests an extension of the approved length of stay. Where the addition is medically apparent the medical coordinator is authorized to grant the extension. In all other cases the request is made to the Medical Director.

If the subscriber remains in the hospital longer than the authorized period of time, the IPA is only obligated to compensate the physician and the hospital for the charges incurred during the approved length of stay.

Grievance Procedure

Most IPA's do provide a grievance procedure for members when there is a dispute regarding their services. Where an IPA believes that a physician's practice is not compatible with the goals of the IPA or the HMO, it may request a peer counseling session; some form of continuing medical education or payment of a fine. While it is reserved for the most flagrant abuses, expulsion from the IPA is a course of action available. The quality review and utilization review data are compiled by the IPA staff and distributed to the membership on a frequent basis, usually with some form of interpretation and analysis by the IPA staff.

The economic and demographic environment surrounding the HMO is a key element to its success. The more even the age/sex distribution, the greater the number of employer units (especially the medium size employers) and the lack of dependence of one type of industry, the more certain the IPA has a chance to succeed. Dependence on a large labor union can be as detrimental as dependence on a large employer.

Massive lay-offs or strikes will reduce payments to the IPA and thereby curtail service availability. There are no fixed rules when marketing an HMO except to avoid

the threat of over-promising results or services. Each marketplace will dictate the competitive edge used by the HMO to attract members. It may be the ability to provide more service for the same amount of dollars or it may require proving an ability to reduce the cost of premiums to the employer, which may mean offering less service.

Market Research

The nexus of any HMO's ability to survive the start-up process and gain a foothold in the marketplace is marketing preparation. Research (and here it is meant quality research) into all the facets of the market to be served should be completed before beginning the benefit design phase. Inclusion of all the other providers and subscribers so as to create a community involvement in the design of the plan insures greater acceptance when the plan is finally unveiled.

Gear the product for the ultimate end user and you will find a positive response to the enrollment offering. Do not rely on sophisticated plan design or the ideals of better management alone to carry the day with the consumer. Personal contact and availability of the IPA staff are crucial during the formative years. They must be energetic and competent professionals, but they must also be able to deal responsively with the public.

Cooperative Ventures

The IPA should not rule out cooperative ventures with traditional Group Insurance companies. Allowing the company the ability to offer the HMO in conjunction with its regular indemnity plan will open doors to more employer units than the HMO marketing staff could possibly cultivate and at a much lower cost. Dual choice marketing ventures with insurance companies also trades on the public's acceptance of the Insurance Company as the health care financier and enhances their willingness to try the HMO knowing that, if the experience proves unsatisfactory, they can revert to the company's indemnity plan.

The IPA can also contract with the Insurance Company to provide utilization review, peer review and cost containment design to provide yet additional IPA revenue. In time additional services such as crisis intervention programs, corporate health monitoring for executives and public health planning could be incorporated into the IPA's revenue producer programs.

As the insurance industry, governmental bodies and employer groups all decry the current state of affairs in health care financing, the opportunities for solutions and IPA's have never been better.

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Professional Liability Insurance: A Long Way To Go

James S. Todd, M.D.

Nothing in the recent history of medicine has so inflamed the profession as has the continuing professional liability problem. Nearly seven years have passed since the national medical malpractice disaster of 1975 when the number of suits filed against physicians rose abruptly. Liability premiums in some areas increased as much as 300 to 800 per cent, causing many commercial insurers to either retrench or abandon the medical liability business altogether and thus producing a climate that forced physicians to enter the insurance business with their own companies.

There was great activity trying to remedy that frightening turn of events. Some 300 pieces of tort legislation were enacted by the 50 state legislatures. National publicity and outcry appeared to cause insurance premiums to level off along with moderating trends in the frequency and severity of claims. With the birth of physician owned companies, coverage again became widely available, leading many physicians to assume the problem had been solved. Now there are 25 medical society-sponsored insurance companies in 23 states, and at least 10 or 12 physician owned companies not sponsored by a medical society. There is a doctor owned reinsurance company (AMACO), and the London reinsurers are not reluctant to deal with doctor companies. Currently three new states are in the final phases of activating captive companies.

On the hospital side, a series of offshore captives emerged and new HHS regulations authorized self-insured trusts at the hospital and group level. Now more than 50 per cent of the 1.2 million hospital beds in this country are in some form of self-funding programs.

Liability Problem Still Exists

In spite of all this activity, the liability problem has not diminished. Indeed, it seems all that was accomplished was a delay in the second coming of the crisis. Malpractice cases are not only increasing in number, but are doing so exponentially. Since 1978, the yearly increase is itself increasing. For example, one state reported claims increased from 280 in 1970 to 904 in 1979, then rose another 40 per cent to 1,262 in 1980. Meanwhile, premiums charged to physicians increased from \$875,000 in 1974 to more than \$16 million in 1980.

In New York, it is reported that the average malpractice loss jumped from \$20,000 in 1978 to \$30,000 in 1980, and there are predictions that the average payment for claims filed in 1981-82 will be nearly \$100,000 when settled some five or six years from now. In one southern state, the physician owned company is seeking a 30 per cent increase in rates for 1982, following a 20 per cent increase earlier this year. The increasing number of claims, larger payouts, and overall inflation mean that the malpractice problem never was under control despite massive attempts both in legislative and economic areas.

To put it in a different perspective, the National Association of Insurance Commissioners published in 1980 a closed claim study of some 72,000 claims between 1975-1978. The findings are no more encouraging: \$876 million was paid during that period, with 39 per cent being paid in the last year of the study. Most discouraging was the 73 per cent increase in cost of defending claims. Sixty per cent of all paid claims involved physicians and 31 per cent hospitals, while losses by physicians amounted to 71 per cent of the total. The average award increased 70 per cent, and awards of \$1 million or more increased from one per 1000 claims paid to three per 1000 by 1978. Today, awards in excess of \$1 million dollars are commonplace.

Accomplishments

The profession has a right to be proud of its accomplishment in the professional liability insurance field. Best & Co. in October 1981 wrote, "Of the 50

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largest writers of medical malpractice insurance, 28 are recently formed professionally sponsored companies. They wrote more than \$633 million in premiums or 42.5 per cent of the total in 1980. In 1979, the 25 professionally sponsored insurers in the top 50 wrote 36.5 per cent of the business. An impressive record for companies that have been in existence for no more than six years." An impressive record, but not one that has solved the problem.

In 1981, the 25 doctor owned companies insured 99,392 physicians and showed assets of \$1.9 billion dollars! Year end 1980, these companies reported 24,982 outstanding cases confirming the startling figure of one claim for every 4 to 5 physicians. Looking at the countrywide malpractice balance sheet for the latest 12 months reported showed written premium of \$965,950,000. Losses (including those incurred but not reported) were \$905,125,000. Total cost of defending these claims was reported as \$366,474,000 of which an estimated \$300,000,000 went to attorneys for the defense! The acknowledged underwriting loss based on these figures is \$466,726,000 which means investment profit needs to be 50 per cent just to break even. And finally the cost of processing and defending claims has risen from 25 per cent of the premium dollar four years ago to 43 per cent during the last quarter, an appalling figure that means less than 50 cents on each premium dollar is available to pay injured parties.

However sophisticated one is economically, these figures have to send a shudder through the physician, and one might hope the public also.

System Out of Control

The system is out of control with no one clearly benefiting. Yet it has been terribly difficult to make any real headway in ameliorating the problem. One reason might be that all things considered, the magnitude of the problem on the national scale does not evoke sympathy for the physician or concern over the contribution to the total health care cost. The \$1 billion dollar annual premium paid by the physician is 0.1 per cent of the entire service component of the gross national product, 0.4 per cent of our 1980 total health care spending, and an average of 2.5 per cent of the physician's gross income, actually falling from 3.2 per cent of gross in 1977. Expressed in these terms, it hardly becomes a national issue, yet when expressed in terms of patient care and physician integrity its importance is paramount.

Initially, the doctor-owned companies—with their tight business practices, malpractice prevention programs, innovative claims management, legislative changes, and the appearance of more conservative courts and juries—assumed they would substantially reduce malpractice losses, when in fact there has not

been much, if any, improvement. Perhaps all that was done to alleviate the symptoms of the problem: unavailability. Perhaps also these companies relieved the pressures for badly needed changes in the malpractice reparations system.

And this is why the second phase of the malpractice crisis, that of cost, is now here. All of the great expectations have not occurred. For most companies, there is little left to be streamlined in the insurance mechanism. Something more fundamental is needed, and that will require a complete reorganization and reorientation toward the professional liability problem.

First, it must be acknowledged that the basis of the malpractice problem is malpractice, whether real or imagined. Eighty per cent of the losses occur in 20 per cent of the cases. A recent study showed that 36 per cent of a series of cases admitted to a general medical service suffered iatrogenic illness, 9 per cent of which were life threatening, and 2 per cent actually resulting in death. Add to this imagined damage, and one wonders if there is any mechanism in the world that will be adequate for compensation.

The Problem Won't Disappear

Second, don't ever expect the problem to disappear. No one is perfect and mistakes will always be made. Litigation seems the American way, and is unlikely to diminish in volume. Roller coaster economics contribute to the avariciousness and need of society to be compensated. The issue really is how best to contain the problem, and this will require the efforts of insurers and medical professionals alike as they try to prevent claims through education of public and profession.

Third, deal with reality. Physicians don't know much about insurance, and insurance people don't know much about the vagaries of medical care. The expertise of these two groups must be sharply focused and not allowed to compete. Furthermore, society has little understanding, and certainly no sympathy for the physician's situation. They will not bail out the profession willingly, and efforts directed toward tort reform and legislative relief must be reasonable and not self-serving. Malpractice is a medical problem, not a legal one, and those injured as a result of negligence are entitled to fair and prompt compensation. By the same token, however, the profession needs to be protected from the more avaricious elements of society.

Fourth, the assertion of malpractice claims is a signal to the profession as to how well it is doing in the broadest sense. The physician must realize that loss prevention is important to him professionally as well as economically.

Fifth, it is important to recognize that as yet there is no demonstrably effective system to cope with the problem of professional liability. Any new program has to be viewed with some degree of skepticism, and no new

idea should be ignored. Economic parameters probably for some time will be the standard by which progress is judged, but fail to tell the whole story.

The Bottom Line

The bottom line of all of this should be improvement of patient care. After all, that is the prime interest of physicians. Viewed in this fashion, the realities of the insurance world can be translated into protection for patients. Hostilities can then be directed toward the situations that produced the damage, and all will be benefited.

It is certain that without modification of current attitudes toward professional liability, little real progress can be made. Far more is known about the problem now than in the 70's; great assets and talents are being brought to bear and the organizations through which to make it all work are in place. To fail in the solution of professional liability will be an indictment of the whole profession, and the consequence may be more devastating than now can be imagined.

- Dr. Todd, V.P., Physicians Insurance Association of America, 130 Prospect St., Ridgewood, NJ 07450.

Impact of Liability Insurance on Health Care Cost in Florida

Vernon B. Astler, M.D.

As the frequency and severity of medical malpractice claims have escalated in Florida, so has the cost of professional liability insurance for physicians, hospitals, and other health care providers. Physicians and others, when faced with rapidly escalating premiums, have had no alternative to passing these costs on to their patients, thus increasing the cost of medical care. It is impossible to establish definitely how much of the fees each patient encounters will go toward paying the premium for professional liability insurance, but in recent years we have seen an increase in fees every year that premium increases have been announced.

The Florida Medical Association has sponsored a group Professional Liability Insurance plan for its members since 1963. During this time we have gathered data on over 11,000 closed claims and over \$150 million in paid losses for our Florida physicians. The data is presented in order to show the magnitude of frequency (the number of claims) and severity (the average cost of settling a claim) that has occurred in this period of time.

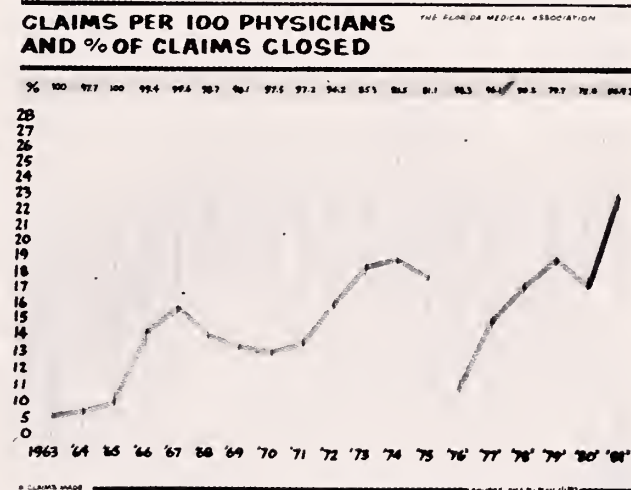
Frequency of Claims

Figure 1 shows the increased frequency of claims by policy year since 1963. Note the alarming rate of claims per 100 physicians for the period 1963 through 1975. The broken graph in 1975-1976 is there to mark the end of the employers' (1963-1972) plus Argonaut's experience (1973-1975) and the beginning of our physician-owned company on December 1, 1975.

The increase in claims shown is similar to other states with the exception of the drop of 8 per cent in claims in 1980 as compared with 1979. Florida was the only state to report such a decrease. This decrease continued through the first quarter of 1981 and then disappeared with the net result being that claims frequency for 1981 was an alarming 43 per cent over 1980, or 35 per cent over 1979.

The decrease in claims in 1980 may have been due to the enactment of the recovery of defense costs law which become effective in July, 1980. We think initially it served as a deterrent to plaintiffs filing suits, but after 6-9 months the plaintiffs once again began to file suits in unprecedented numbers. Another possible explanation for the dramatic increase in claims in 1981 may be due to our activity in malpractice prevention. During 1981 we had 6,000 Florida Medical Association members at seminars where the early reporting of claims was stressed.

Figure 1



Cost Per Claim

Figure 2 shows the ever-increasing average cost per claim since 1963. Here again we see a break in the graph delineating the beginning of our company. The dotted line at the end of the graft shows the actuary's predictions which were used to calculate the premiums for 1982. The yellow bar across the top of the graph shows the percentage of claims closed by policy year. This is important in evaluating the accuracy of the data for any given year. If only a small percentage of claims are closed for any one year, as in 1981, the data usually changes for the worse, when re-examined one year later. Generally,

The Author

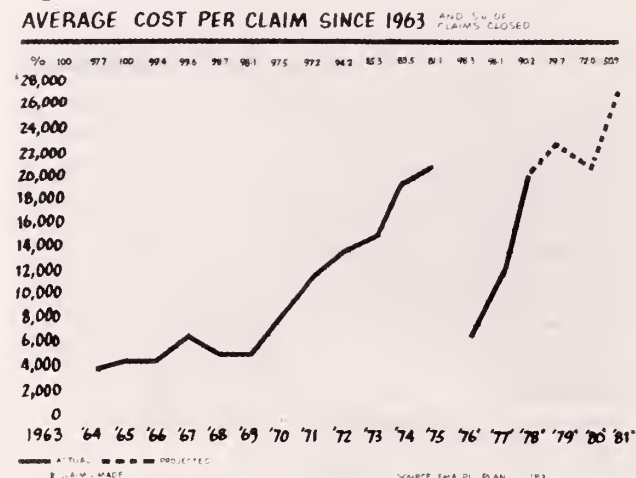
VERNON B. ASTLER, M.D.

Dr. Astler, of Boynton Beach, is Chairman of the Board of the Florida Physicians' Insurance Reciprocal and is a Past President of the Florida Medical Association.

the less expensive claims are settled early and the larger claims drag on for years.

Claims frequency times claims severity plus administrative costs minus anticipated investment income equals premium for any given year. The premium increases which we experienced in 1981 and 1982 are directly related to the first two graphs as the other variables have remained relatively constant.

Figure 2



Large Claims

Of great concern to all of us is the increasing frequency and severity of claims that we have seen since 1969 of \$100,000 or more (Figure 3). Claims of such magnitude were unknown in Florida during the period of 1963 through 1968. During this same period, most of us carried limits of \$100,000/\$300,000 and paid from \$100 per year to \$300 per year in premium. \$1 million umbrella protection for professional liability, our homes, automobiles, etc., was available for approximately \$120 per year. With the appearance of the jumbo jury awards, we have seen the disappearance of this umbrella coverage and the rapid escalation of premiums. Here again, the dotted line represents the actuary's projections.

Figure 4 shows the 156 claims paid or reserved in excess of \$100,000, which the Reciprocal and its predecessor, the Florida Medical Association-PLI Trust have accumulated since December 1, 1975. Note that there are 19 specialty groups in this study. The claims represent about 2 per cent of all the claims which we are currently defending in court, and account for one-half of the total loss reserves which the Reciprocal has established. The other 98 per cent (less than \$100,000) account for the other one-half of the loss reserves.

OB/GYN has more claims in this category followed by family practice, anesthesiology, general surgery, and

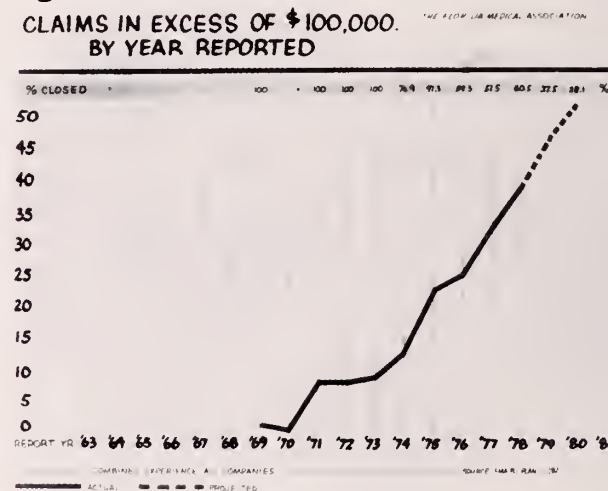
pediatrics. Pediatrics has 13 claims paid and reserved for \$100,000 or more. These 13 claims account for 92 per cent of all of the total pediatric losses.

Premium History

Figure 5 shows the premium history of the FMA-sponsored PLI program since 1963 as well as the Joint Underwriting Association (JUA) rates since 1975. Note that in 1963 our low premium was \$99 per year and our high was \$235. Compare this with 1982 with a low of \$964 and a high of \$18,996. The increase in the high premium represents an increase of 8,000 per cent during this period, while the increase in the low premium charged was 973 per cent.

The rate increases of the Reciprocal for years 1976, 1977, 1978, and 1979 were a result of the step-wise increases inherent in a claims-made format where it is four years before the policy reaches maturity and then should level off if all other variables remained constant. Such was the case in our program. Physicians who entered the program in 1976 (the majority of the Reciprocal members) experienced these normal step-wise rate increases and, in fact, experienced a slight decrease in 1980 over 1979.

Figure 3



On February 28, 1980 the Florida Supreme Court, after three considerations, ruled that the medical mediation panels enacted July 1975 were unconstitutional. Since that time we have experienced a premium increase of 26 per cent in 1981 and a premium increase of 17.5 per cent in 1982 with a call for a surplus contribution of 12.5 per cent in 1982. We have determined that among those cases which were won in mediation and thus dropped by the plaintiff that the company saved at least

**Figure 4— Study of 156 Claims in Excess of \$100,000
(Reserved and Paid)**

	# Reserved	# Paid	Total	Average Cost Per Claim Reserved	Average Cost Per Claim Paid	Total Paid & Reserved	% of Total
Allergy	1	0	1				.2
Anesthesiology	8	7	15				11.5
Cardiac Surgery	1	1	2				1.1
Cardiology	1	1	2				1.1
Emergency Medicine	6	6	12				6.7
Family Practice (3 types)	10	10	20				13.0
General Surgery	10	6	16				10.0
Internal Medicine	6	5	11				7.0
Neurology	1	2	3				1.8
Neurosurgery	2	2	4				2.0
OB/GYN	13	10	23				17.8
Ophthalmology	1	0	1				.2
Orthopedics	5	4	9				4.6
Otolaryngology	1	4	5				4.0
Pathology	2	1	3				1.0
Pediatrics	12	1	13				8.4
Radiology	6	6	12				8.0
Thoracic Surgery	2	0	2				1.0
Urology	1	1	2				.6
TOTALS	89	67	156	\$267,826	\$333,183	\$46,159,780	100
1/bcs/bp							(Total reserved for these claims = \$23,836,510)
10-20-81							(Total paid for these claims = \$22,323,270)

\$1.96 million. The recovery of costs bill has not had the same effect on the cost of claims to this point in time.

The increase in premiums that each of us must pay for our liability insurance is real and has become a major factor in the overhead of most physicians. Using the rates of 1979, the first mature year of our claims-made format as a baseline, how does this translate into increased costs for the physician and his patients?

A general surgeon in Dade County whose rate in 1979 was \$10,383 paid \$15,240 in 1982 for the same coverage which represents an increase of \$4,857—46.8% increase. Assuming that this physician performed 200 major cases (hospital operating room) per year, this increase passed along to this group of patients would amount to \$76.20 per operation for malpractice insurance costs in 1982.

Similarly, pediatricians in Dade County whose premium in 1979 was \$2,073 paid \$5,272 in 1982 for identical coverage with a resulting increase of \$3,199 (or 154 per cent increase). Pediatricians experienced a classification change in 1982 because of a loss ratio (the

ratio of premiums collected to losses both paid and reserved) of 177 percent. Assuming that the average pediatrician has 5,000 office visits per year, this malpractice insurance charge passed along to the patients would amount to \$1.05 per office visit. I am told that several pediatricians increased their fee per office visit upon receiving notice of the premium increase in December.

Conclusion

In conclusion, during the six-year existence of your physician-owned company, we have seen tort reforms enacted and the mediation panels declared unconstitutional. We experienced a stabilization of rates for professional liability insurance during the period of 1975 through 1980 with an approximate 56 per cent increase for the years 1981 through 1982. We have noted an increase in the jumbo awards by juries throughout our state since 1975. These awards are real and insurance carriers have paid them while passing this through to

**Figure 5— FMA Sponsored PLI Program
Premium History (1963 - 1982)**

The following chart shows the steady increase in the cost of professional liability insurance in Florida.

Year	High	Low		
1963 (1)	\$ 235	\$ 99		
1971 (1)	3,723	332		
1972 (1)	3,425	383		
1973 (2)	4,325 (2)	381		
1974 (2)	4,974	438		
1975 (2)	9,252	902		
1976 (3)	8,243 *	814 *		
1977 (4)	10,988	846		
1978 (4)	14,021	848		
1979 (4)	13,000	865		
1980 (4)	12,806	764		
1981 (4)	14,612	763		
1982 (4)	18,996 *	964 *		

**JUA
(\$250/\$750 Limit
Occurrence)**

High Low

\$29,590 \$2,947
29,590 2,947
29,590 2,947
35,774 3,563
26,902 2,679
26,902 2,679
26,902 2,679
38,990 2,570

- (1) Employers (\$100,000/\$300,000 Occurrence)
(2) Argonaut Insurance Company (\$250,000/\$750,000 Occurrence)
(3) FMA PLI Trust (\$500,000 claims made)
(4) Florida Physicians' Insurance Reciprocal (\$500,000 claims made)
* Includes Required Contribution to Surplus

their insured physicians and hospitals. The physicians and hospitals have had no choice but to pass them on to their patients in the form of increased fees. There is no doubt that the worsening of the malpractice picture in Florida is having an increasing effect on the cost of health care to the public.

- Dr. Astler, 2800 S. Seacrest Blvd., Boyton Beach 33435.

Habits May Be Worth Breaking

Robert E. Windom, M.D.

From the very beginning our training as physicians leads us into forming habits to save time, energy, and, in some cases, lives. Such habits are good, but once established, they are difficult to alter or break.

The physician marches on with time and so do those habits developed during the early days of training and practice. They work well and they can make one's life easier, but only if the individual has a sound reason to change them will there be a change. Even though a physician might know of a different way to do things, the ease of a familiar way offers in itself resistance.

With increasing demands for service, one must budget every minute of his day. The routine soon becomes second nature.

If time and technology stood still, and our society remained constant, then there might not be any need to consider a change in one's habits. This is how we would all like life to be and for years such was the case in the private practice of medicine. Today, the technology of sophisticated tests and procedures continues to make it increasingly easy to diagnose and treat patients. Consequently, physician's orders for routine events become rote.

Why the concern?

Simply because things have not remained equal. The costs of these advanced studies have escalated almost beyond reality and the number of studies available has advanced beyond what anyone would have thought 10 years ago.

Right now the decision on what course to follow in the private practice of medicine is in the hands of physicians. However, the consumers whom most physicians think of as patients are demanding that health care costs be reduced. Where is the cost reduction going to come?

Who is going to pull back on the throttle?

Every physician directing patient care must reanalyze his habits and assume his share of the responsibility. Physicians must begin to analyze the orders they give. Just to tell physicians they must change is not enough. That won't even scratch the surface. It is time for a jolt or a sudden shock to break these long standing reflexes that have been established to carry out a habit.

The question is who is going to give the shock treatment? We see and hear rumblings by everyone involved in health care but those noises on the horizon are not strong enough to affect the majority of physicians. The jolt must come from within our own ranks and it must come soon! Consumers aren't going to tolerate the present situation much longer.

If physicians are to continue as the leaders in the health care field some habits may have to be changed. The value to each individual physician in changing some long engrained habits is evident in order to preserve his or her independence in the private practice of medicine. If we don't change our ways then physician input and leadership in health care are going to be undermined.

Only the practicing physician of today can make the determination if long standing habits are worth breaking. Right now physicians still have that choice. Let us heed all of the information and data that is available and change those habits that add increased costs but do not enhance the quality of medical care delivery. Only by that method will our profession be able to maintain its leadership role in American medicine.

● Dr. Windom, 1750 S. Osprey Ave., Sarasota 33579.

The Author

ROBERT E. WINDOM, M.D.

Dr. Windom, President-Elect of the Florida Medical Association, practices internal medicine in Sarasota.

The FMA Committee on Medical Education Announces a “Seminar on the Process of Aging”

Featuring . . .



Eric Pfeiffer, M.D.
Tampa, Florida

Topic:

“Health Care of the Elderly: The New Frontier”

Topic:

“The Changes Which Occur in a Doctor When He Commits Himself to the Continuing Care of the Elderly Who Have Many Diseases”



Eugene A. Stead Jr., M.D.
Durham, North Carolina



Robert D. Terry, M.D.
Bronx, N.Y.

Topic:

“The Neurobiology of Aging and Senile Dementia”

2:00 p.m. — Thursday, May 6 — Diplomat Hotel, Hollywood, Florida

“One Good Reason To Attend the Florida Medical Association Annual Meeting”

Coalitions for Health Care

(Editor's Note: In 1981, the American Medical Association House of Delegates adopted Report VV of the Board of Trustees, Subject: Coalitions for Health Care. Among other things, the report endorses voluntary coalitions on a local, state or regional basis. The AMA distributed the report to all state medical associations, county medical societies and national specialty societies. Here in Florida, the report was distributed a second time to county medical societies by FMA President Sanford A. Mullen, M.D. Because of the important nature of the topic, we believe this material is worth repeating for all members of the FMA).

Please do not hesitate to let us know if we can be of assistance.

98/79

Encl.

cc:

William T. Branch, M.D., Chairman
Committee on Business and Industry Relations

Louis C. Murray, M.D., Chairman
Council on Legislation

**Florida Medical Association, Inc.
Jacksonville, Florida
M E M O R A N D U M**

TO: County Medical Society Presidents, Executive Directors and Secretaries
FROM: Sanford A. Mullen, M.D.
President
SUBJECT: Coalitions for Health Care

In all probability, your County Society has received the attached correspondence from Dr. James Sammons, Executive Vice President of the AMA, regarding Coalitions for Health Care, including the joint statement adopted recently by major national organizations.

Because of the great importance of this crucial issue, we are providing you with an additional copy to insure that your County Society has access to this significant action. We hope that it will be helpful to you as a guide in determining the appropriate actions at the local level in addressing the problem of medical and health care costs. As I am sure you are aware, the FMA is pursuing this issue at the State level and we will be happy to assist your County Society in taking the initiative to establish a basis for a coalition in your area if you desire.

**American Medical Association
Chicago, Illinois**

To: Executive Directors,
State Medical Associations
County Medical Societies
National Medical Specialty Societies
SUBJECT: Coalitions for Health Care

As the profession has been informed in both the January 18 *AMA Newsletter* and the January 29 *American Medical News*, the Association is a co-signer with five other national organizations—the American Hospital Association, Blue Cross and Blue Shield Associations, the Business Roundtable, the Health Insurance Association of America, and the AFL—CIO—in a statement on “Coalitions for Health Care.” That statement, as presented to the House of Delegates in Board of Trustees Report VV and adopted at the 1981 Interim Meeting, is enclosed.

The Board of Trustees, and I, personally, wish to emphasize the importance of this initiative. That we have entered a period of reevaluation, reassessment, and perhaps retrenchment in expenditures for health is apparent to all of you as you scan your daily newspapers.

It also seems obvious that the continued independence of the medical profession will depend, at least in part, on its taking the lead in making health care both more effective and more efficient.

Over and over in the past decade the profession has emphasized—to Presidents, to Congress, and to the public—that effective and efficient care is a product of local effort, not of some national “cookbook” or federal legislation. In this Coalition effort, we not only repeat the philosophy but indicate the broad outlines of a mechanism to implement it.

It is clear to me, as one of the participants in the development of this statement, that we—the national organizations involved in the Coalition—can only give suggestions and guidelines, and that the real work of the Coalition will—as always—be done at the state and local level. What we have achieved is a model: a gathering of the major forces involved in providing and financing health care in the private sector, a model we strongly urge state, local, and specialty societies to follow.

We recognize that, outside the health professions themselves, much of the current emphasis on health care has been on the cost side—a natural consequence of the overall national economic concerns. I am pleased, therefore, to inform you that the House of Delegates has made explicit the profession’s continuing concern that quality not be lost sight of. In adopting Board Report VV, the House also recommended that: “The AMA strongly support health care coalitions that include meaningful physician participation, so that primary emphasis is given to quality medical care, including availability and access, as well as recognizing the importance of cost effectiveness and cost containment.”

I personally urge you to begin (if you have not already) the establishment of coalitions in your own state and your own community. The AMA is gearing up to provide you with information and suggestions to make your effort more effective, but the basic element lies in your own community knowledge and initiative.

Sincerely,

James H. Sammons, M.D.

Report of the Board of Trustees

Report: VV
(I-81)

Subject: Coalitions for Health Care
Presented by: Joseph F. Boyle, M.D., Chairman
Referred to: Reference Committee A
(Russel H. Patterson, M.D., Chairman)

For more than three years the American Medical Association has worked diligently to establish contacts at the national and local level between physicians and other health care providers and business and industry groups for the purpose of discussing common concerns related to the delivery of health care. Early in this program, the Association’s representatives met with representatives of more than 100 of the nation’s leading industrial concerns, and over the last 18 months has concentrated on assisting with and encouraging these same types of on-going discussions at the local level.

As an extension of this activity, the American Medical Association has been holding discussions with the American Hospital Association, the Blue Cross/Blue Shield Association, the Business Roundtable, the Health Insurance Association of America, and the American Federation of Labor and Congress of Industrial Organizations with a view toward marshaling the support of these groups behind this coalition activity. Attached to this report is a statement that has been agreed to in principle by representatives of the organizations listed, and it has subsequently been approved by the Board of Trustees.

The Board recommends that the House of Delegates endorse the attached statement on Coalitions for Health Care as a means of marshaling further support for the coalition activities now proceeding at the local level.

Coalitions for Health Care

The country is in a period of review and reassessment of private and public policies relating to the costs, planning and delivery of health care.

Health care expenditures have taken an increasingly larger share of the nation’s gross national product. While many efforts have been made to restrain rising costs, the problem persists and is of great concern to all health care purchasers (both governmental and private), consumers, and providers. All must share in the responsibility for seeking solutions.

The Federal Government, as a matter of policy, is calling on the states and localities and on the private sector for increased responsibility for health care insurance and services. The states, localities, and the private sector are in the process of redefining their roles in financing and providing personal health services. In this setting and out of these concerns in the past several years, there has grown up a variety of voluntary coalitions of hospitals, doctors, insurers, business, labor, and other concerned groups, public and private, in different combinations and participations.

As representatives of national organizations, we have been reviewing the experience of these local and state coalitions in their diverse forms and activities. Only a relatively few of the more than 70 coalitions of which we have records and reports seem to have advanced beyond the important stage of discourse and exchanging views to the operation of specific programs or projects of cooperative activities. With health care costs rising more rapidly in the recent period and with the prospect of a diminished role, the need for organizing new coalitions and improving the effectiveness of existing coalitions is vital.

We are agreed upon the following conclusions and support the following programs:

Formation of Coalitions

1. We endorse, in this period, the potentials of voluntary coalitions on a local, state, or regional basis. We encourage our members or local affiliates to participate together in such coalitions, recognizing that at the outset local conditions and relationships may appropriately result in different configurations, patterns of membership, and programs. But, in due course, for effective results, all concerned groups need to be included. An individual organization is unlikely to have the same impact if acting alone.

2. We view the most appropriate focus of local coalitions generally to be the costs of delivery of medical care, and the numerous factors which locally influence such costs, with related attention to the quality of care, to the availability of proper medical care and access to such care by various groups within the population.

3. Experience shows that, after an initial period of dialogue and getting acquainted, a local coalition is likely to accomplish more with a limited agenda of a very few priority projects. Appropriate staff resources drawn from or financed by coalition members are essential to help collect information, define priorities, and implement action decisions.

Analysis of Local Health Systems

Local coalitions may find it helpful early to make an inventory or survey of local resources and problems, if that has not already been done. Data for this first level of assessment should be largely available, or can be developed from existing sources. Key areas of analytical concern include:

1. The rate of increase in total health care costs in the area, the rate of increase in particular costs (hospitals, physicians, etc.) and the reasons for these increases.

2. Utilization of acute in-patient hospital days of care in the area, how the rate compares with other areas, the utilization rates of different population groups, and the steps which can be taken to reduce high utilization where excessive patterns are identified. A similar approach can be taken in regard to utilization rates of other health care services, e.g., long term care, physician visits, laboratory and X-ray services, psychiatric care, etc. The effectiveness of existing utilization review systems should be assessed.
3. Existing health care facilities and services in the community, with an assessment of the availability of needed services, especially for the disadvantaged and unemployed. Excess facility capacity should also be assessed.
4. Analysis of health benefits packages and options (e.g. HMOs and other alternative delivery systems), as well as gaps in coverage of services.

Potential Actions

Following the analysis of the local health care system the coalition's next step is to decide on a few priority projects. These projects could take the form of either a demonstration to gain experience, establish relationships and test policies or a community-wide action. Among projects with a demonstrated potential for improving cost and delivery of health care are:

1. Encourage efforts to place less emphasis on expensive in-patient technology and greater emphasis on alternative forms of care, including ambulatory and home care. Among the activities which may accomplish this objective are:
 - a. Redesign insurance benefits to emphasize preventive, primary and home care.
 - b. Case management and utilization review with both health care and financial protection for patients.
 - c. Encourage efforts to modify use of hospital beds, with protection of patients, workers and trustees, to make the most appropriate use of community health resources.
2. Increase access to care:
 - a. Efforts to finance and provide health care for the unemployed and others who do not have access to care.
 - b. Efforts to mitigate the impact of federal (and state and local) budget changes on health care in the community.

3. Increase opportunities to discuss and develop the most cost effective and equitable forms of provider payment.
4. Develop more effective programs of health promotion and disease prevention at the work place.

We intend to issue and distribute this statement to our constituent bodies or members. We further intend to follow the developments in local coalitions for health care and to provide appropriate reports and assistance.

American Hospital Association

The Business Roundtable

American Medical Association

Health Insurance Association of America

Blue Cross and Blue Shield Associations

The American Federation of Labor and Congress
of Industrial Organizations

16th ANNUAL BENEFIT ART SHOW

Formal Champagne Opening for Artists and Guests

THURSDAY, MAY 6, 1982

6:00 p.m.

EXHIBIT RULES AND REGULATIONS

Read Rules Carefully

1. All entries must be original work.
2. Pictures must be framed and wired for hanging. (Stands will be provided for sculpture, etc.)
3. Each entry must have a typed card indicating Name, Address, Medium, Dimensions and Title. Please list price if entry is for sale; otherwise, mark not for sale (NFS).
4. Only one artist's name should be listed for each registration slip.
5. A registration fee of \$10 will be charged for each entry. Entry fees are tax deductible. Entry fees will be donations to AMA-ERF, divided equally among Florida medical schools.
6. All registration slips and checks must be sent in together no later than April 15, 1982.
7. All pre-registered entries are to be delivered by hand to the Exhibit Hall at the Diplomat Hotel no later than 3:00 p.m., Wednesday, May 5. Shipped entries will be refused.
8. All entries must be picked up noon Saturday, and must be signed out before removal from the show.
9. We will not be responsible for entries not picked up by 1:00 p.m., Saturday, May 8, 1982.
10. Doctors, their wives and children, are eligible to enter.

Kindly enter my registration to show in the Benefit Art Show.

Fee of \$_____ for _____ entries is enclosed. I agree to abide by the rules and regulations for exhibiting material in the show.

Name _____

Address _____

City _____ County _____

I will be showing in the following categories: Please check (X) appropriate category (categories) and division applying to your entry (entries). Division: (1) Adult _____ (2) Youth _____

Category: () A. Painting. Include any media in color: acrylic, oil, casein, collage, watercolor, pastel, etc.

Size: _____ (H) x _____ (W) To be hung on wall.

() B. Graphics. Include a pen and ink, charcoal, photography, etc.

Size: _____ (H) x _____ (W)

() C. Crafts. Include sculpture, pottery, ceramics, mosaic, weaving, etc.

Size: _____ (L) x _____ (D) x _____ (H)

() I am the son/daughter of a Florida physician. Age _____


An "Editor's Award," given by *The Journal of the Florida Medical Association*, will be used on the cover of a future issue of *The FMA Journal*.

A registration fee of \$10 will be charged for each entry. Make checks payable to: FMA-A Art Show, Mrs. R. H. Owrey, 5701 Mariner Court, Tampa, Florida 33609, (813) 879-1478.

NOTE: It is most important to know the size of your art objects, paintings, etc., to enable us to display them more professionally. We will not be responsible for damage or loss of any entry.

REGISTRATION DEADLINE — APRIL 15, 1982

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your patient receives the original allopurinol.*



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in Step-1
antihypertensive
therapy...***

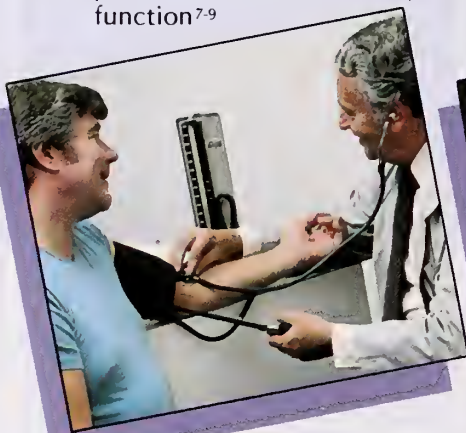
For your hypertensive patients,
Long-acting
Zaroxolyn[®] gives
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Efficacy

Start with Zaroxolyn because of its unsurpassed effectiveness in Step-1 therapy.¹⁻⁴

Stay with Zaroxolyn because it maintains effectiveness in long-term therapy^{1,5,6}... and minimizes the need for Step-2 agents.

- ☐ Zaroxolyn's effectiveness is maintained even in the presence of reduced kidney function⁷⁻⁹



Compliance

Stay with Zaroxolyn because it maintains 24-hour blood pressure control with simple once-daily dosage, and only 4% discontinue therapy due to side effects!



Safety

Stay with Zaroxolyn because clinically significant side effects are rare!

- ☐ Low incidence of changes in serum K⁺, glucose metabolism, or uric acid levels



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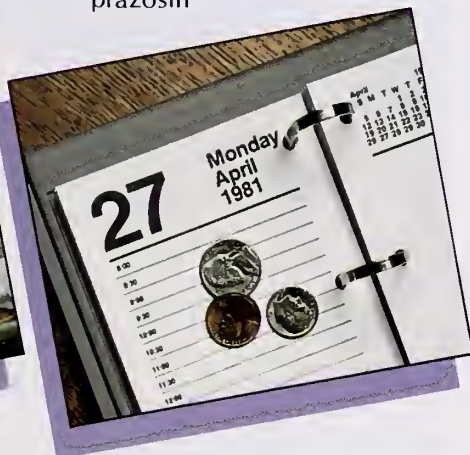
Compatibility

Add to Zaroxolyn easily if Step-2 agents become necessary.

- ☐ Permits lower doses of Step-2 agents to minimize side effects
- ☐ Allows flexible dosage titration, in contrast to fixed-dose combinations

Economy¹⁰

- ☐ Less expensive than most other diuretics
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- ☐ Less expensive than methyldopa, clonidine, or prazosin



Start with...stay with...and add to...

Long-acting

Zaroxolyn[®]

(metolazone)

Gives you what you want in
Step-1 antihypertensive therapy

Please see following page
for prescribing information.



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2½ mg, 5 mg, 10 mg tablets

Gives you what you want in Step-1 antihypertensive therapy

- ☐ Unsurpassed Step-1 efficacy in mild to moderate hypertension
- ☐ True once-daily dosage for excellent patient compliance
- ☐ Positive side effect profile
- ☐ Strong foundation for stepped-care therapy
- ☐ Long-term economy

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents, and also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma; allergy or hypersensitivity to Zaroxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. **Not for pediatric use.** **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium

depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. Zaroxolyn 10 mg tablets contain FD&C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD&C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin sensitivity. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg, edema of cardiac failure—5 to 10 mg, edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg

References: 1. Data on file, Medical Department, Pennwalt Pharmaceutical Division. 2. Sambhi MP, Eggena P, Barrett JD, et al: A crossover comparison of the effects of metolazone and hydrochlorothiazide therapy on blood pressure and renin-angiotensin system in patients with essential hypertension, in Sambhi MP (ed): *Systemic Effects of Antihypertensive Agents*. New York: Stratton, 1976, pp 221-245. 3. Pilewski RM, Scheib ET, Misage JR, et al: Technique of controlled drug assay in hypertension: V. Comparison of hydrochlorothiazide with a new quinethazone diuretic, metolazone. *Clin Pharmacol Ther* 12:843-848, 1971. 4. Fotiu S, Mroczek WJ, Davidov M, et al: Antihypertensive efficacy of metolazone. *Clin Pharmacol Ther* 16:318-321, 1974. 5. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Current Therapeutic Research* 20:745-750, 1976. 6. Dornfeld L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Current Therapeutic Research* 18:527-533, 1975. 7. Puschett JB: Physiologic basis for the use of new and older diuretics in congestive heart failure. *Cardiovascular Medicine* 2:119-134, 1977. 8. Craswell PW, Ezzat E, Kopstein J, et al: Use of metolazone, a new diuretic, in patients with renal disease. *Nephron* 12:63-73, 1973. 9. Bennett WM, Porter GA: Efficacy and safety of metolazone in renal failure and the nephrotic syndrome. *J Clin Pharmacol* 13:357-364, 1973. 10. *Drug Topics Red Book 1981*, and manufacturers' suggested prices.

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NOTES AND NEWS

Leadership Conference Examines Health Care Financing

The Annual FMA Leadership Conference was conducted at Lake Buena Vista in January, and for the first time in recent memory the entire one and a half-day program was devoted to a single topic: health care financing.

Speakers from many parts of the East and the Midwest and as far west as California were brought to Lake Buena Vista to examine this complex and important subject from virtually every angle, including the viewpoints of state and federal governments, the practicing physician, the consumer, and business. More than 200 people including 187 members of the Florida Medical Association attended all or parts of the sessions on Saturday and Sunday, January 30-31. They represented 29 county medical societies and 13 FMA-recognized specialty groups.

FMA President Sanford A. Mullen, M.D., of Jacksonville, and President-Elect Robert E. Windom, M.D., of Sarasota, presided at the sessions. Speakers included:

Eli Ginzberg, Ph.D., Director, Conservation of Human Resources, Columbia University, New York City; Gary J. Clarke, J.D., Assistant Secretary for Health Planning, Department of Health and Rehabilitative Services, Tallahassee; Mr. Samuel J. Tibbitts, a founder and Co-Chairman of the National Voluntary Effort, Los Angeles, Calif.; James S. Todd, M.D., Vice President of the Physicians' Insurance Association of America, Ridgewood, N.J.

Vernon B. Astler, M.D., Chairman of the Board of the Florida Physicians' Insurance Reciprocal, Boynton Beach; U.S. Sen. Dave Durenberger of Minnesota; State Rep. Richard S. Hodes, M.D., Tampa; Charles P. Hayes Jr., M.D., Chairman of the FMA Council on Health Care Financing, Jacksonville; Mr. Stephen A. Doiron, President and Chief Executive Officer, Caribbean Atlantic Resource Enterprises, Inc., Boca Raton.

Mr. Roy Pfautch, President of Civic Service, Inc., St. Louis, Mo.; Edward N. Brandt Jr., M.D., Assistant Secretary for Health, Department of Health and Human Services, Washington, D.C.; Mr. Robert A. Carpenter, Manager of Health Care Cost Containment, Republic Steel Corp., Cleveland, Ohio; Miss Bess Myerson, consumer advocate and former Miss America, New York City; and James H. Sammons, M.D., Executive Vice President of the American Medical Association, Chicago.

The various speakers approached the subject of cost of health care from different perspectives, but there was agreement that health costs must be brought under control and industry, patients, providers and government all must cooperate if there is to be any successful braking.

Papers presented at the Conference are published elsewhere in this Special Issue of *The Journal* devoted to Health Care Financing.

13 Florida M.D.s Elected To ACP Fellowship

Thirteen Florida physicians are among the latest class of 354 doctors nationally to be elected to Fellowship in the American College of Physicians.

They will be inducted formally at the College's Annual Session in Philadelphia in April. ACP headquarters identified the newly-elected Florida Fellows as:

Orlando Maytin, M.D., Fort Lauderdale; Robert W. Curry Jr., M.D., and Charles E. King Jr., M.D., both of Gainesville; Fernando L. Martinez-Catinchi, M.D., Hialeah; Isabella Sharpe, M.D., Jacksonville; and Peter H. Segall, M.D., North Miami Beach.

Sheldon J. Taub, M.D., Palm Beach Gardens; Philip Altus, M.D., Edward A. Eikman, M.D., Willard S. Harris, M.D., German Ramirez, M.D., and Frank B. Vasey, M.D., all of Tampa; and John W. Forman, M.D., Winter Haven.

Cardiovascular Research Chair Established at University of Florida

A \$1 million endowed faculty chair in cardiovascular research has been established at the University of Florida College of Medicine.

The professorship was made possible through a \$600,000 gift raised in the Heart Fund campaign in the Pinellas-Sarasota-Manatee County area. The gift will be matched by a \$400,000 state contribution under Florida's Eminent Scholars Trust Fund, which was created by the Legislature in 1979.

An eminent cardiologist will be recruited to occupy the new chair.

The \$600,000 gift was presented by the Suncoast Chapter of the American Heart Association to UF President Robert Q. Marston, M.D., on February 12.



Health Care Economist Eli Ginzberg, Ph.D., of New York City, photo at left, was the leadoff speaker at the FMA leadership/Health Care Financing Conference. In photo on right, FMA President Sanford A. Mullen, M.D., Jacksonville, introduces Gary J. Clarke, J.D. (papers in hand), Assistant Secretary of the Florida Department of Health and Rehabilitative Services, Tallahassee.



Charles P. Hayes Jr., M.D., of Jacksonville, Chairman of the FMA Council on Health Care Financing, described FMA's historical interest in medical economics for conference participants in photo at left. In photo on right, former Miss America and consumer advocate Bess Myerson and AMA Executive Vice President James H. Sammons, M.D., spoke at the final session of the Conference.



In left photo, U.S. Senator Dave Durenberger of Minnesota (left), who gave the Saturday luncheon address, shares an informal moment with FMA President-Elect Robert E. Windom, M.D., of Sarasota. Vernon B. Astler, M.D., in right photo, described the impact of professional liability insurance on health care costs in Florida. Dr. Astler is Chairman of the Florida Physicians' Insurance Reciprocal.

Camp for Children with Pulmonary Problems

Frederick L. Bloom, M.D., Chairman, Pediatric Lung Disease Committee of the Florida Lung Association and the Medical Director of "Sunshine Station", has announced that the 8th session will be held again at Camp Lake Swan in Melrose, east of Gainesville on June 20-26.

The Camp is for children with bona fide *pulmonary problems*, not for kids with allergic rhinitis, nor for siblings of other patients who are eligible to attend camp.

The fee is reasonable; children whose families are not able to pay for the camp may get "camperships" through the local lung association.

Dr. Bloom asks that patients be properly screened to make sure that they do qualify.

Nearly 170 children attended the camp in 1981.

16 Florida Physicians Join College of Chest Physicians

The latest class of 215 inductees into the American College of Chest Physicians included 16 Florida physicians. All were inducted during a convocation held in conjunction with the College's 47th Annual Scientific Assembly in San Francisco, Calif., recently.

New members from Florida are:

Roy M. Arnold, M.D., Niceville; Mathis L. Becker, M.D., Plantation; Hernando Bernal, M.D., and Stephen M. Kreitzer, M.D., both of Tampa; Liberato Chapa, M.D., Clearwater; Victor F. Doig, M.D., Ormond Beach; Arie Fester, M.D., Miami Beach; and C. Duncan Finlay, M.D., Sarasota.

Jose F. Font, M.D., Hialeah; Herry H. Kijner, M.D., Coconut Creek; C. K. Sachidanantha Mallan, M.D., Fort Lauderdale; George M. Mestas, M.D., and Peter M. Sidell, M.D., both of Fort Myers; R. P. Portu, M.D., Crystal River; William M. Sherman, M.D., Margate; and Bahman Venus, M.D., Jacksonville.

Pioneer Florida Pathologist Honored on 80th Birthday



James N. Patterson, M.D., of Tampa, one of Florida's first pathologists, was honored with a luncheon on February 15 in celebration of his 80th birthday anniversary. The luncheon was arranged by the Board of Directors of the Southwest Florida Blood Bank, Inc., on which Dr. Patterson has served for 35 years.

Among notables attending were fellow pathologist and FMA President

Dr. Patterson

Sanford A. Mullen, M.D., of Jacksonville, who presented the honoree with an FMA award in recognition of his many years of service to the people of Florida.

"Dr. Pat", as he is affectionately known, is a former President of the Hillsborough County Medical Association, the Florida Society of Pathologists, the Florida Association of Blood Banks and the American Board of Pathology.

Medicaid Drug Changes Put Into Effect December 1

The Florida Department of Health and Rehabilitative Services has put changes in the Florida Medicaid Prescribed Drug Services Program into effect as of December 1, 1981.

Cost containment due to reduction in federal funds was blamed for one change that identifies specific drugs or drug categories that will be excluded or limited for reimbursement; and for another change that lists requirements for dispensing and billing buffered and enteric coated aspirin.

A third change transfers from the physician to the pharmacist responsibility for initiation of the "Drug Exception Request" form.

Details of the changes have been mailed to Florida's Medicaid providers. Additional information may be obtained by contacting: Mr. Rod Presnell, Pharmacist Consultant, Medicaid Program Development, 1309 Winewood Blvd., Building 6, Room 240, Tallahassee 32301.

Two Hospitals in State Earn CME Accreditation

The FMA Committee on Medical Education has announced the accreditation of two hospital continuing medical education programs in Florida.

They are the programs of the Baptist Medical Center and affiliated Jacksonville Wolfson Children's Hospital in Jacksonville; and of the Parkway General Hospital in North Miami Beach. In both cases, provisional accreditation for two years was granted.

Accreditation by the Committee and by the national Accreditation Council for Continuing Medical Education allows CME providers to sponsor or co-sponsor CME activities that are certified for AMA Category I Credit.

The FMA Committee on Medical Education, at its meeting on January 29, also renewed the CME accreditation of the Dade County Medical Association for six years.

FMAA Annual Meeting Announcement

The FMA Auxiliary Convention Committee has finalized plans for the FMA/FMAA Annual Meeting on May 5-9.

President Ruth Coleman, President-Elect Gloria Nunn, FMA Auxiliary Staff Russ Berge and FMA Executive Director Don Jones have arranged for business of the FMA Auxiliary House of Delegates to be held on Thursday afternoon and Friday. Members and their spouses are urged to attend all functions including the FLAMPAC and Awards Luncheons as well as the art show.

The Hospitality room on the Mezzanine level will be open for refreshments on Thursday and Friday.

Florida Surpasses Previous AMA Membership Record

In 1981, Florida surpassed its previous year record of AMA members for the fourth consecutive year.

This achievement will be recognized at the 10th Annual AMA National Leadership Conference and a commemorative plaque will be awarded the FMA.

Jean Jones Perdue, M.D., Wins AMA's Benjamin Rush Award

Jean Perdue, M.D., a specialist in geriatric medicine from Miami Beach, Florida, has won the American Medical Association's Dr. Benjamin Rush Award for outstanding citizenship and public service.

The honor, named for the Revolutionary War-era physician and patriot, consists of a \$2,500 stipend and a commemorative plaque.

Dr. Perdue has dedicated more than 20 years to improving the health of citizens of Metropolitan Dade County through her work as director and consultant to the county office of health services and through her continuous service in many public and private health and welfare agencies. She has served on the Heart Association of Greater Miami, Florida Council on Aging, Miami Heart Institute, White House Conference on Aging, Dade-Monroe Lung Association and Commission on the Ministry to the Aging of the Diocese of Southeast Florida.

Dr. Purdue is a member of the Federal Council on Aging, the American Medical Women's Association, the American Geriatric Association, the American Rehabilitation Association and the Dade County Mental Health Association.

In 1952, she was among the first to be named a Woman of Achievement by the Business and Professional Women's Club of Miami. In 1969, Dr. Perdue was honored by the dedication of a clinical research pavilion at the Miami Heart Institute in her name and in 1973 she received the Distinguished Service Award from the Florida Council on Aging.

Dr. Perdue's most recent honor was the Partnership for Health Award, bestowed in May, 1981, by the Health Systems Agency of South Florida, Inc.

Dr. Perdue received her medical degree in 1932 from the University of Virginia Medical School, Charlottesville. She has practiced internal medicine and cardiology in the Greater Miami area since 1934.

Also receiving the Dr. Benjamin Rush Award this year is Dr. Charles B. Wheeler Jr., a pathologist and former mayor of Kansas City, Missouri.

Dr. Dann Appointed

O. Townsend Dann, M.D., of Miami, has been appointed a Training Analyst by the Board of Professional Standards of the American Psychoanalytic Association. Training analysts are certified to train psychiatrists to become psychoanalysts.

Dr. Deal Appointed To Liaison Committee



Dr. Deal

William B. Deal, M.D., Dean of the University of Florida College of Medicine, has been appointed to the national Liaison Committee on Medical Education as a representative of the Association of American Medical Colleges.

LCME is a 12-member body responsible for the accreditation of medical schools in North America. The body also provides consultation to new or developing medical schools, and establishes standards for the guidance of the state medical licensing boards.

Dr. Deal's appointment is for three years.

ACP Issues Selective Guide To Preventive Health Care

Although an annual physical exam and history-taking by a personal physician has been a widely accepted rule of thumb, it is probably not necessary for the apparently healthy individual, the American College of Physicians stated in a recommendation recently released.

A program tailored to each patient's history, age and sex is a more effective and efficient approach, the 53,000-member national medical society maintained.

This recommendation, issued after a review of the literature on periodic health examinations and based on four recent studies, appears as a special report in the December *Annals of Internal Medicine*, the College's scientific journal, and the *ACP Observer*, the ACP membership monthly tabloid. Accompanying this Medical Practice Committee-developed statement is a chart that visually summarizes the age- and sex-related recommendations. The chart can help primary care physicians make decisions about which tests and procedures to perform during a routine examination.

"Although histories and physical examinations can be effective ways of detecting disease," Dr. Ball continued, "there are not enough data to justify taking thorough histories and examinations each year for each patient. This selective approach to health care," he said, "helps make the best use of physician and patient time and the health care dollar."

ACP Announces New Clinical Efficacy Recommendations

The American College of Physicians (ACP) endorses the Arthritis Foundation's recommendation that, at the present time, hyperbaric oxygen therapy is an unacceptable form of treatment for any known form of arthritis. Although there are metabolic changes in joints of individuals with inflammatory arthritis, particularly rheumatoid arthritis, which include low oxygen tension, increased levels of metabolites and elevated CO₂, it is unclear whether such changes aggravate the condition.

Percutaneous transluminal coronary angioplasty (PTCA) is an investigational procedure. The immediate efficacy and safety of the procedure is not established.

Candidates for PTCA should have intractable angina inadequately controlled with maximal medical therapy; objective evidence of myocardial ischemia; normal ventricular function; and proximal, discrete, accessible, noncalcific, segmental, high-grade obstruction of a coronary vessel. More effort must be made to collect adequate clinical, hemodynamic, and angiographic data in all patients prior to the procedure and to obtain systematically clinical and angiographic follow-up on such patients following the procedure. These efforts will be best coordinated by the National Heart, Lung and Blood Institute registry, in which the College encourages physicians performing PTCA to participate, and by the adoption of multicenter, randomized clinical trials.

Intravenous histamine has not been shown to be an effective treatment for Meniere's disease, acute and sudden hearing loss, and headache. Indeed, there is evidence that histamine may provoke headaches. Intravenous histamine may produce palpitations, tachycardia, and syncope.

Patients with decreased cardiac output or reduced perfusion to essential organs are at particular risk from intravenous histamine induced alterations in cardiovascular function. In addition, it is unclear whether repeated intravenous histamine might produce some of the severe symptoms of mastocytosis which are thought to be due to histamine release.

The CEAP study evaluates the clinical efficacy of nonsurgical laboratory tests and procedures to determine outmoded tests and encourage newer, more accurate health care and significant dollar savings to result from the medical community's use of their findings.

The three-year project, funded by a \$650,412 grant from the John A. Hartford Foundation, is headed by J. Sanford Schwartz, M.D., assistant professor of medicine at the University of Pennsylvania School of Medicine.

Dr. McGuigan Identified As Prominent in Scientific Literature



Dr. McGuigan

A University of Florida professor has been identified as one of the most often cited scientific researchers in the world's scientific literature.

James E. McGuigan, M.D., was included among 1,000 eminent scientists of the world in a list published in a recent issue of "Current Contents." The list was compiled by the Institute for Scientific Information in Philadelphia following a survey of worldwide scientific literature during the period 1965 to 1978.

Dr. McGuigan, Professor and Chairman of the Department of Medicine at the University of Florida College of Medicine in Gainesville, is widely known for his research in gastroenterology. His research concerning peptic ulcers and gastrointestinal hormones won him the Distinguished Achievement Award of the American Gastroenterological Association in 1974.

**MARK YOUR CALENDARS
FOR FMA ANNUAL MEETING
MAY 5-9, 1982**

John W. C. Johnson, M.D. Named to Professorship



Dr. Johnson

An expert in the fields of fetal development and physiology of pregnancy has accepted the appointment as the first occupant of the Harry Prystowsky Chair in Reproductive Medicine at the University of Florida.

The appointment of John W. C. Johnson, M.D., to the professorship was announced by Eduard G. Friedrich, M.D., Professor and Chairman of the College of Medicine's Department of Obstetrics and Gynecology. "Dr. Johnson will direct and help expand our departments research in perinatal medicine, involving the full range of care for mothers and babies," Dr. Friedrich observed.

The endowed professorship was established several years ago and named for Dr. Prystowsky, who served as Chairman of the Dept. of Obstetrics and Gynecology.

Dr. Johnson's most recent location was at the Johns Hopkins University School of Medicine, where he served as Director of the Division of Maternal and Fetal Medicine, Medical Director of the Adolescent Pregnancy Program, and Director of Resident Education in Obstetrics and Gynecology. He received his M.D. degree at the University of Virginia Medical School.

Prominent Trio of Experts To Address Aging Seminar

Three prominent experts on the human aging process have accepted invitations to speak at a special seminar on the subject at the 108th Annual Meeting of the Florida Medical Association.

The three will speak at a Seminar on the Process of Aging, which is scheduled for 2:00 p.m. on Thursday, May 6, at the Diplomat Hotel in Hollywood, Florida, according to Calvin W. Martin, M.D., of Arcadia, Chairman of the FMA Subcommittee on Annual Meeting Scientific Program.

Dr. Martin said the following had agreed to speak:

- Eric Pfeiffer, M.D., Professor of Psychiatry and Director of the Suncoast Gerontology Center at the University of South Florida, Tampa.

- Robert D. Terry, M.D., Professor and Chairman of the Department of Pathology, Albert Einstein College of Medicine, Bronx, N.Y.
- Eugene A. Stead Jr., M.D., Florence McAlister Professor Emeritus and former Chairman, Department of Medicine, Duke University School of Medicine, Durham, N.C.

Serving as program chairman for the seminar will be Andor Szentivanyi, M.D., Dean of the University of South Florida College of Medicine and a member of the FMA Committee on Medical Education.

Application has been made to the Florida Medical Foundation Committee on Medical Education for co-sponsorship and certification of the complete scientific program for 20 hours of AMA Category I Credit. Other co-sponsors will include the University of Miami School of Medicine, the University of South Florida College of Medicine, and the University of Florida College of Medicine.

The complete scientific program will be published in the April issue of *The Journal*. Programs recently announced include:

WEDNESDAY, MAY 5

SECTION ON INTERNAL MEDICINE

(Co-sponsored by Florida Society of Internal Medicine and Florida Region, American College of Physicians)

Wednesday May 5 — 1:00 p.m. to 4:15 p.m.

Roy H. Behnke, M.D., Tampa
Program Chairman

"Geriatrics"

"Evaluation of Confusion in the Elderly Patient" — Patricia Barry, M.D., Director, Division of Geriatric Medicine, University of South Florida College of Medicine, Tampa.

"Cell Biology of Human Aging" — Leonard Hayflick, Ph.D., Director, Center for Gerontological Studies and Programs, University of Florida College of Medicine, Gainesville.

"Adaptation to Chronic Illness: The Physician's Role" — Eric Pfeiffer, M.D., Professor of Psychiatry and Director, Suncoast Gerontology Center, University of South Florida College of Medicine, Tampa.

"Prescribing for the Elderly" — George J. Caranasos, M.D., Ruth S. Jewett, M.D., Professor of Medicine in Geriatrics, University of Florida College of Medicine, Gainesville.

SECTION ON TRAUMA

(Co-sponsored by Florida Committee on Trauma — American College of Surgeons; Florida Chapter, American College of Surgeons; FMA Committee on Emergency Medical Services; and Florida Chapter, American College of Emergency Physicians)
Wednesday, May 5 — 1:15 p.m. to 3:30 p.m.
Arthur L. Trask, M.D., Boynton Beach
Program Chairman

“Trauma Centers 1982: What Are They? Who Should Go There? Why Have Them Anyway?”

Welcome and Introduction — Arthur L. Trask, M.D., F.A.C.S., Chairman, Florida Committee on Trauma — American College of Surgeons, Boynton Beach.

“Do Trauma Systems Save Lives? The Orange County (Calif.) Experience” — John G. West, M.D., F.A.C.S., Assistant Clinical Professor of Surgery, University of California College of Medicine, Irvine, Calif.

“Trauma System Development: The Missouri Experience” — Frank L. Mitchell, M.D., F.A.C.S., Professor of Surgery, University of Missouri Medical Center, and Chairman, Missouri Committee on Trauma, Columbia, Mo.

“Head and Spinal Cord Trauma: The Florida Neurosurgeons Speak Up” — Donald L. Mellman, M.D., President-Elect, Florida Neurosurgical Society, Tampa.

“Categorizing Emergency Departments As Seen by the Florida Chapter, American College of Emergency Physicians” — Daniel E. Lucas, M.D., President, Florida Chapter, American College of Emergency Physicians, Stuart.

“Trauma Centers in Florida: What’s Happening in Dade and Monroe Counties?” — David Bernstein, M.D., Chief of the Trauma Service, Jackson Memorial Hospital, Miami, and Member of the South Florida Regional EMS Council.

Panel Discussion and Questions and Answers

Moderator: Arthur L. Trask, M.D.

Panelists: John G. West, M.D.
Frank L. Mitchell, M.D.
Donald L. Mellman, M.D.
Daniel E. Lucas, M.D.
David Bernstein, M.D.

THURSDAY, MAY 6

SEMINAR ON THE PROCESS OF AGING

(Sponsored by FMA Committee on Medical Education)
Thursday, May 6 — 2:00 p.m. to 4:00 p.m.
Andor Szentivanyi, M.D., Tampa
Program Chairman

Introduction — Andor Szentivanyi, M.D., Dean, University of South Florida College of Medicine, and Member, Florida Medical Association Committee on Medical Education, Tampa.

“Health Care of the Elderly: The New Frontier” — Eric Pfeiffer, M.D., Professor of Psychiatry and Director, Suncoast Gerontology Center, University of South Florida College of Medicine, Tampa.

“The Neurobiology of Aging and Senile Dementia” — Robert D. Terry, M.D., Professor and Chairman, Department of Pathology, Albert Einstein College of Medicine, Bronx, N.Y.

“The Changes Which Occur in a Doctor When He Commits Himself to the Continuing Care of the Elderly Who Have Many Diseases” — Eugene A. Stead Jr., M.D., Florence McAlister, M.D., Professor Emeritus and former Chairman, Department of Medicine, Duke University School of Medicine, Durham, N.C.

SEMINAR ON MEDICAL MALPRACTICE PREVENTION

(Co-sponsored by Florida Physicians’ Insurance Reciprocal)

Thursday, May 6 — 4:30 p.m. to 6:30 p.m.
James W. Walker, M.D., Jacksonville
Program Chairman

“Introduction to Florida Medical Malpractice Problem” — Vernon B. Astler, M.D., Chairman, Florida Physicians’ Insurance Reciprocal, Boynton Beach.

“What We as Physicians Do to Get Sued and the Prevention of Suits” — Robert S. Brittain, M.D., President, Medical Liability Consultants Program, Inc., Denver, Colo.

“How Do You Win?” — Robert S. Brittain, M.D., Denver, Colo.

“How to Make a Cheap Suit Expensive — Fighting Too Long, Failure to Cooperate, Etc.” — Robert S. Brittain, M.D., Denver, Colo.

FRIDAY, MAY 7

SECTION ON PEDIATRICS

(Co-sponsored by Florida Pediatric Society)

Friday, May 7 — 8:00 a.m. to 10:45 a.m.

Thomas M. Zavelson, M.D., Gainesville

Program Chairman

“Common Problems in Pediatric Gastrointestinal Disease: Medical and Surgical Approaches”

Program to be Announced.

SECTION ON GASTROENTEROLOGY

(Co-sponsored by Florida Gastroenterologic Society)

Friday, May 7 — 8:00 a.m. to 10:45 a.m.

Jamie S. Barkin, M.D., Miami

Program Chairman

“Inflammatory Bowel Disease Update”

“Differential Diagnosis of Inflammatory Bowel Disease” — Chester Cassel, M.D., Clinical Professor of Medicine, University of Miami School of Medicine, and Senior Attending Physician, Cedars of Lebanon Hospital, Miami.

“The Role of Radiological Studies in Inflammatory Bowel Disease” — Robert Feltman, M.D., Chief of Radiology, Cedars of Lebanon Hospital, Miami.

“Pharmacotherapy Update” — Howard Manten, M.D., Instructor in Medicine, University of Miami School of Medicine, Miami.

“Rectal Preservation Operations in Inflammatory Bowel Disease” — Donald Buckner, M.D., Professor of Surgery and Chief of Pediatric Surgery, University of Miami School of Medicine, Miami.

“Cancer Surveillance in Inflammatory Bowel Disease” — Arvey I. Rogers, M.D., Professor of Medicine, University of Miami School of Medicine, and Chief of Gastroenterology, Veterans Hospital, Miami.

DIALOGUE

(Presented through the Courtesy of Pfizer Laboratories)

Friday, May 7

8:30 a.m. to 10:45 a.m. and 1:30 p.m. to 4:30 p.m.

(Note: In each Dialogue segment, the guest professor makes an opening statement of five to ten minutes, and the remainder of the hour is devoted to questions and answers about the topic.)

“Diabetes: What’s New in Management” — B. R. Tulloch, M.D., Associate Professor of Medicine, University of Texas Medical School, Houston, Texas.

“Metabolic Factors in Cardiovascular Disease” — B. R. Tulloch, M.D., Houston, Texas.

“Rational Approach To Use of Nonsteroidal Anti-inflammatory Drugs in Arthritis and Painful Conditions” — Jacques R. Caldwell, M.D., Clinical Professor of Medicine, University of Florida College of Medicine, Gainesville.

“Rational Use of Psychotropic Drugs in the Middle-Age Patient” — Fred Charatan, M.D., Chief of Psychiatry, Jewish Institute for Geriatric Care, New Hyde Park, N.Y., and Associate Professor of Clinical Psychiatry, State University of New York, Stonybrook, N.Y.

“Angina Pectoris — New Concepts/New Treatment” (Film)

SECTION ON THORACIC AND CARDIOVASCULAR SURGERY

(Co-sponsored by Florida Society of Thoracic and Cardiovascular Surgeons)

Friday, May 7 — 1:00 p.m. to 4:00 p.m.

Franklin G. Norris, M.D., Orlando

Program Chairman

“Experience, Methods and Results of Percutaneous Transluminal Angioplasty” — Andreas R. Gruentzig, M.D., Department of Cardiology, Emory University School of Medicine, Atlanta, Ga.

“Experience with Unusual Cases Involving Percutaneous Transluminal Angioplasty” — Richard Hawkins, M.D., Department of Radiology, University of Florida College of Medicine, Gainesville.

“Pitfalls and Reservations and Subsequent Surgical Intervention Following Percutaneous Transluminal Angioplasty” — Francis Robischek, M.D., Thoracic and Cardiovascular Surgeon, Charlotte, N.C.

“Experience with Combined Surgery and Angioplasty” — Arthur Roberts, M.D., Division of Thoracic and Cardiovascular Surgery, University of Florida College of Medicine, Gainesville.

SECTION ON PREVENTIVE MEDICINE

(Co-sponsored by Florida Society for Preventive Medicine)

Friday, May 7 — 2:00 p.m. to 4:00 p.m.

Jorge Deju, M.D., Longwood

Program Chairman

"The Status of Public Health in Florida" — James T. Howell, M.D., Deputy Secretary and Staff Director, Health Program Office, Florida Department of Health and Rehabilitative Services, Tallahassee.

"An Overview of Tuberculosis in Florida: Among the Haitian Population and in School-Age Children"

— Clifford H. Cole, M.D., Director of the State Tuberculosis Control Program, Florida Department of Health and Rehabilitative Services.

SECTION ON PATHOLOGY

(Co-sponsored by Florida Society of Pathology)

Friday, May 7 — 2:00 p.m. to 5:00 p.m.

Isaac Cohen, M.D., Miami Beach

Program Chairman

"Senescence of the Immune System: Current Concepts" — John Stablien, M.D., Assistant Professor of Medicine, Division of Allergy and Immunology, Department of Internal Medicine, University of South Florida College of Medicine, Tampa.

The Alfred Lewis Award Presentation

"Pathologic Aspects of Aging" — Arkadi Rywlin, M.D., Director, Department of Pathology and Laboratory Medicine, Mount Sinai Medical Center of Greater Miami, and Professor of Pathology, University of Miami School of Medicine, Miami.

SECTION ON DERMATOLOGY (SECTION I)

(Co-sponsored by Florida Society of Dermatology)

Friday, May 7 — 3:00 p.m. to 5:00 p.m.

Henry W. Menn, M.D., Miami

Program Chairman

***Dermatopathology Clinical
Pathological Conference***

Selected cases of dermatologic problems of interest to practicing dermatologists will be discussed in detail from the clinical pathological standpoint by the members of the Department of Dermatopathology, University of Miami School of Medicine.

Participants: Neal S. Penneys, M.D., Ph.D., Professor of Dermatology

Alexander Kowalczyk, M.D., Assistant Professor of Dermatology

Guest Participant: Ronald Barr, M.D., Associate Professor of Dermatology, University of California School of Medicine, Irvine, California.

SATURDAY, MAY 8

SECTION ON DERMATOLOGY (SECTION II)

(Co-sponsored by Florida Society of Dermatology)

Saturday, May 8 — 8:00 a.m. to 12:00 noon

Henry W. Menn, M.D., Miami

Program Chairman

Selected Clinical and Scientific Presentations on Current Concepts in Dermatology Presented by the University of Miami School of Medicine faculty

The Norman Fogel, M.D., Memorial Lectureship in Clinical Dermatology

Guest Lecturer: Ronald Barr, M.D., Associate Professor of Dermatology, University of California School of Medicine, Irvine

The Wiley Sams, M.D., Lectureship

Guest Lecturer: Jeffrey Callen, M.D., Assistant Professor of Medicine (Dermatology) University of Louisville School of Medicine, Louisville, Kentucky

SECTION ON UROLOGY

(Co-sponsored by Florida Urological Society)

Saturday, May 8 — 9:00 a.m. to 10:00 a.m.

Michael P. Small, M.D., Miami Lakes

Program Chairman

"CT Scanning of the Genitourinary Tract" — Freddie Gargano, M.D., Clinical Professor of Radiology, University of Miami School of Medicine, Miami.

SECTION ON OPHTHALMOLOGY

(Co-sponsored by Florida Society of Ophthalmology)

Saturday, May 8 — 9:00 a.m. to 12:00 noon

(Note: The Section on Ophthalmology will be presented in the Retter Auditorium of the Anne Bates Leach Eye Hospital/Bascom Palmer Eye Institute, 900 N.W. 17th Street, Miami. Physicians wishing to attend this session should arrange their own transportation.

Edward W. D. Norton, M.D., Miami
Program Chairman

"Indications for Laser Treatment in Glaucoma" — Elizabeth Hodapp, M.D., Assistant Professor of Ophthalmology, University of Miami School of Medicine, Miami.

"Diagnosis and Management of Macular Disorders in the Aged Population" — J. D. M. Gass, M.D., Professor of Ophthalmology, University of Miami School of Medicine, Miami.

"Diagnosis and Management of Corneal Disorders in the Elderly Patient" — William Culbertson, M.D., Assistant Professor of Ophthalmology, University of Miami School of Medicine, Miami.

"Venous Obstructive Retinal Disease" — John G. Clarkson, M.D., Associate Professor of Ophthalmology, University of Miami School of Medicine, Miami.

SECTION ON INTERNATIONAL COLLEGE OF SURGEONS

(Co-sponsored by Florida State Surgical Division,
International College of Surgeons)

Saturday, May 8 — 1:00 p.m. to 3:00 p.m.

Robert H. Hux, M.D., Leesburg
Program Chairman

"The Treatment of Unstable Coronary Artery Disease" — Steven J. Phillips, M.D., Associate Professor of Surgery, COMS, Drake University, Des Moines, Iowa.

"Surgery in the Post-Op Cardiac Surgery Patient" — Steven J. Phillips, M.D., Des Moines, Iowa.

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As seen on admission



After one week of penicillin V-K therapy



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Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. No treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

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INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® (cloxacillin sodium)	Given penicillin V-K
<i>Staphylococcus aureus</i>	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
<i>Staphylococcus aureus</i> and <i>Streptococcus pyogenes</i>	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth	(14 patients)	9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic <i>Streptococcus</i>	(1 patient)	0	1
TOTALS:	102 patients	52 patients	50 patients

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported

the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus*, 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes*, and 1% beta-hemolytic *Streptococcus*.†
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.

- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

†The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K

TEGOPEN®

(cloxacillin sodium)

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of the skin and skin structures**

WARNING:

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established

PRECAUTIONS:

The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:

Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose

stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:

Adults: 250 mg. q. 6h.

Children: 50 mg./Kg./day in equally divided doses q. 6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLY:

Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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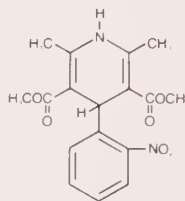
NEW
PROCARDIA[®]
(NIFEDIPINE) Capsules 10 mg

Please see PROCARDIA[®] prescribing information on next page.

PROCARDIA® CAPSULES nifedipine

For Oral Use

DESCRIPTION: PROCARDIA (nifedipine) is an antianginal drug belonging to a new class of pharmacological agents, the calcium channel blockers. Nifedipine is 3,5-pyridinedicarboxylic acid, 1,4-dihydro-2,6-dimethyl-4-(2-nitrophenyl)-, dimethyl ester, C₁₇H₁₈N₂O₆, and has the structural formula:



Nifedipine is a yellow crystalline substance, practically insoluble in water but soluble in ethanol. It has a molecular weight of 346.3. PROCARDIA CAPSULES are formulated as soft gelatin capsules for oral administration each containing 10 mg nifedipine.

CLINICAL PHARMACOLOGY: PROCARDIA (nifedipine) is a calcium ion influx inhibitor (slow channel blocker or calcium ion antagonist) and inhibits the transmembrane influx of calcium ions into cardiac muscle and smooth muscle. The contractile processes of cardiac muscle and vascular smooth muscle are dependent upon the movement of extracellular calcium ions into these cells through specific ion channels. PROCARDIA selectively inhibits calcium ion influx across the cell membrane of cardiac muscle and vascular smooth muscle without changing serum calcium concentrations.

Mechanism of Action: The precise means by which this inhibition relieves angina has not been fully determined, but includes at least the following two mechanisms:

1) **Relaxation and prevention of coronary artery spasm:** PROCARDIA dilates the main coronary arteries and coronary arterioles, both in normal and ischemic regions, and is a potent inhibitor of coronary artery spasm, whether spontaneous or ergonovine-induced. This property increases myocardial oxygen delivery in patients with coronary artery spasm, and is responsible for the effectiveness of PROCARDIA in vasospastic (Prinzmetal's or variant) angina. Whether this effect plays any role in classical angina is not clear, but studies of exercise tolerance have not shown an increase in the maximum exercise rate-pressure product, a widely accepted measure of oxygen utilization. This suggests that, in general, relief of spasm or dilation of coronary arteries is not an important factor in classical angina.

2) **Reduction of oxygen utilization:** PROCARDIA regularly reduces arterial pressure at rest and at a given level of exercise by dilating peripheral arterioles and reducing the total peripheral resistance (afterload) against which the heart works. This unloading of the heart reduces myocardial energy consumption and oxygen requirements and probably accounts for the effectiveness of PROCARDIA in chronic stable angina.

Pharmacokinetics and Metabolism: PROCARDIA is rapidly and fully absorbed after oral administration. The drug is detectable in serum 10 minutes after oral administration, and peak blood levels occur in approximately 30 minutes. It is highly bound by serum proteins. PROCARDIA is extensively converted to inactive metabolites and approximately 80% of PROCARDIA and metabolites are eliminated via the kidneys. The half-life of nifedipine in plasma is approximately two hours. There is no information on the effects of renal or hepatic impairment on excretion or metabolism of PROCARDIA.

Hemodynamics: Like other slow channel blockers, PROCARDIA exerts a negative inotropic effect on isolated myocardial tissue. This is rarely, if ever, seen in intact animals or man, probably because of reflex responses to its vasodilating effects. In man, PROCARDIA causes decreased peripheral vascular resistance and a fall in systolic and diastolic pressure, usually modest (5–10 mm Hg systolic), but sometimes larger. There is usually a small increase in heart rate, a reflex response to vasodilation. Measurements of cardiac function in patients with normal ventricular function have generally found a small increase in cardiac index without major effects on ejection fraction, left ventricular end diastolic pressure (LVEDP) or volume (LVEDV). In patients with impaired ventricular function, most acute studies have shown some increase in ejection fraction and reduction in left ventricular filling pressure.

Electrophysiologic Effects: Although, like other members of its class, PROCARDIA decreases sinoatrial node function and atrioventricular conduction in isolated myocardial preparations, such effects have not been seen in studies in intact animals or in man. In formal electrophysiologic studies, predominantly in patients with normal conduction systems, PROCARDIA has had no tendency to prolong atrioventricular conduction, prolong sinus node recovery time, or slow sinus rate.

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta-blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Increased Angina Beta Blocker Withdrawal: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients usually receiving a beta blocker have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event, as the unloading effect of PROCARDIA would be expected to be of less benefit to these patients, owing to their fixed impedance to flow across the aortic valve.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. See Warnings.

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to

diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: See Indications and Warnings. Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Carcinogenesis, mutagenesis, impairment of fertility: Nifedipine was administered orally to rats for two years and was not shown to be carcinogenic. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose. *In vivo* mutagenicity studies were negative.

Pregnancy: Pregnancy category C. Nifedipine has been shown to be fetotoxic in rats when given in doses 30 times the maximum recommended human dose. Nifedipine was embryotoxic (increased fetal resorptions, decreased fetal weight, increased stunted forms, increased fetal deaths, decreased neonatal survival) in rats, mice and rabbits at doses of from 3 to 10 times the maximum recommended human dose. In pregnant monkeys, doses 2/3 and twice the maximum recommended human dose resulted in small placentas and underdeveloped chorionic villi. In rats, doses three times the maximum human dose and higher caused prolongation of pregnancy. There are no adequate and well-controlled studies in pregnant women. PROCARDIA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

ADVERSE REACTIONS: In multiple-dose U.S. and foreign-controlled studies in which adverse reactions were reported spontaneously, adverse effects were frequent but generally not serious and rarely required discontinuation of therapy or dosage adjustment. Most were expected consequences of the vasodilator effects of PROCARDIA.

Adverse Effect	PROCARDIA (%) (N = 226)	Placebo (%) (N = 235)
Dizziness, light-headedness, giddiness	27	15
Flushing, heat sensation	25	8
Headache	23	20
Weakness	12	10
Nausea, heartburn	11	8
Muscle cramps, tremor	8	3
Peripheral edema	7	1
Nervousness, mood changes	7	4
Palpitation	7	5
Dyspnea, cough, wheezing	6	3
Nasal congestion, sore throat	6	8

There is also a large uncontrolled experience in over 2100 patients in the United States. Most of the patients had vasospastic or resistant angina pectoris, and about half had concomitant treatment with beta-adrenergic blocking agents. The most common adverse events were the same ones seen in the controlled trials, with dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

Several of these side effects appear to be dose related. Peripheral edema occurred in about one in 25 patients at doses less than 60 mg per day and in about one patient in eight at 120 mg per day or more. Transient hypotension, generally of mild to moderate severity and seldom requiring discontinuation of therapy, occurred in one of 50 patients at less than 60 mg per day and in one of 20 patients at 120 mg per day or more.

In addition, 2% or fewer of patients reported the following: **Respiratory:** Nasal and chest congestion, shortness of breath. **Gastrointestinal:** Diarrhea, constipation, cramps, flatulence. **Musculoskeletal:** Inflammation, joint stiffness, muscle cramps. **CNS:** Shakiness, nervousness, jitteriness, sleep disturbances, blurred vision, difficulties in balance. **Other:** Dermatitis, pruritus, urticaria, fever, sweating, chills, sexual difficulties.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

In a subgroup of over 1000 patients receiving PROCARDIA with concomitant beta blocker therapy, the pattern and incidence of adverse experiences was not different from that of the entire group of PROCARDIA treated patients (see **Precautions**).

In a subgroup of patients with a diagnosis of congestive heart failure as well as angina, dizziness or light-headedness, peripheral edema, headache or flushing each occurred in one in eight patients. Hypotension occurred in about one in 20 patients. Syncope occurred in approximately one patient in 250. Myocardial infarction or symptoms of congestive heart failure each occurred in about one patient in 15. Atrial or ventricular dysrhythmias each occurred in about one patient in 150.

Laboratory tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have already been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

OVERDOSAGE: Although there is no well documented experience with PROCARDIA overdosage, available data suggest that gross overdosage could result in excessive peripheral vasodilation with subsequent marked and probably prolonged systemic hypotension. Clinically significant hypotension due to PROCARDIA overdosage calls for active cardiovascular support including monitoring of cardiac and respiratory function, elevation of extremities, and attention to circulating fluid volume and urine output. A vasoconstrictor (such as norepinephrine) may be helpful in restoring vascular tone and blood pressure, provided that there is no contraindication to its use. Clearance of PROCARDIA would be expected to be prolonged in patients with impaired liver function. Since PROCARDIA is highly protein-bound, dialysis is not likely to be of benefit.

DOSAGE AND ADMINISTRATION: The dosage of PROCARDIA needed to suppress angina and that can be tolerated by the patient must be established by titration. Excessive doses can result in hypotension.

The starting dose is one 10 mg capsule, swallowed whole, 3 times a day. The usual effective dose range is 10–20 mg three times daily. Some patients, especially those with evidence of coronary artery spasm, respond only to higher doses, more frequent administration, or both. In such patients, doses of 20–30 mg three or four times daily may be effective. Doses above 120 mg daily are rarely necessary. More than 180 mg per day is not recommended.

In most cases, PROCARDIA titration should proceed over a 7–14 day period so that the physician can assess the response to each dose level and monitor the blood pressure before proceeding to higher doses.

If symptoms so warrant, titration may proceed more rapidly provided that the patient is assessed frequently. Based on the patient's physical activity level, attack frequency, and sublingual nitroglycerin consumption, the dose of PROCARDIA may be increased from 10 mg t.i.d. to 20 mg t.i.d. and then to 30 mg t.i.d. over a three-day period.

In hospitalized patients under close observation, the dose may be increased in 10 mg increments over four to six-hour periods as required to control pain and arrhythmias due to ischemia. A single dose should rarely exceed 30 mg.

No "rebound effect" has been observed upon discontinuation of PROCARDIA. However, if discontinuation of PROCARDIA is necessary, sound clinical practice suggests that the dosage should be decreased gradually with close physician supervision.

Co-Administration with Other Antianginal Drugs: Sublingual nitroglycerin may be taken as required for the control of acute manifestations of angina, particularly during PROCARDIA titration. See **Precautions, Drug Interactions** for information on co-administration of PROCARDIA with beta blockers or long-acting nitrates.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA Capsule contains 10 mg of nifedipine. PROCARDIA Capsules are supplied in amber glass bottles of 100 capsules (NDC 0069-2600-66). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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*Reference: 1981/82 American Druggist Blue Book

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Liquid Tonic

A Tonic for Geriatric Patients

A pleasant tasting tonic containing iron, vitamins, minerals, and an analeptic. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

DESCRIPTION Forty-five milliliters of SU-TON contains the following ingredients: Pentylenetetrazol, 30 mg • Niacin, 50 mg • Vitamin B-1, 10 mg • Vitamin B-2, 5 mg • Vitamin B-6, 1 mg • Vitamin B-12, 3 mcg • Manganese (as Manganese Sulfate), 1 mg • Magnesium (as Magnesium Sulfate), 2 mg • Zinc (as Zinc Sulfate), 1 mg • Iron (as Ferric Pyrophosphate, Soluble), 22 mg • Alcohol, 18%

INDICATIONS AND USAGE SU-TON contains pentylenetetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

CONTRAINDICATIONS Epilepsy, convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

ADVERSE REACTIONS Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE Drug dependence has not been reported with SU-TON.

OVERDOSAGE Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage. Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSEAGE AND ADMINISTRATION One tablespoonful (15 ml) 3 times a day 20-30 minutes before meals. This drug is not for use in children under 12 years of age.

HOW SUPPLIED Bottles of 473 ml (16 fl. oz.)

Federal law prohibits dispensing without prescription.

NOC 0524-1015-16

February 1982

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†Due to susceptible organisms.

1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.

2. Multicenter trials. Data to be published.

See important information on page after next.

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3. Data on file. Wyeth Laboratories.
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Wyeth Laboratories
Philadelphia, Pa 19101

Cyclapen®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNING5) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Branchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.

†depending on severity

How Supplied Tablets 250 mg and 500 mg in bottles of 100. Oral Suspension 125 mg and 250 mg per 5 ml in bottles to make 100 ml and 200 ml of Suspension.

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SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

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INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

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MEETINGS

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APRIL

Laboratory Supervisory and Management Skills for Personnel Problems and the Challenges Ahead, Apr. 1-2, Jacksonville. For information: CAMA Regional Programs, 2100 West Harrison St., Chicago, IL 60612.

Critical Care Medicine '82, Apr. 1-3, Lake Buena Vista. For information: Alan Varraux, M.D. and Barry E. Sieger, M.D., (305) 841-5144.

Continuins Ambulatory Peritoneal Dialysis (CAPD) An Update, Apr. 2, Miami. For information: Carlos A. Vaamonde, M.D., Dept. of Continuing Medical Education, P.O. Box 016960, Miami 33101.

Glaucoma Detection Workshops, Apr. 2-4, Gainesville. For information: Charles E. Aucremann, M.D., Box 13, College of Medicine, 12901 North 30th St., Tampa 33612.

Family Practice Weekend, Apr. 2-4, Tampa. For information: Charles Aucremann, M.D., Dept. of Family Medicine, 12901 N. 30th St., Tampa 33612.

Fifteenth Family Practice Review, Apr. 5-9, Kissimmee. For information: University of Florida College of Medicine, Box J-233, Gainesville 32610.

Comprehensive Review Course for ECFMG, FLEX and VQE (in Spanish), Apr. 5-July 16, Miami. For information: Rafael Penalver, M.D., University of Miami, P.O. Box 016960, Miami 33101.

Spinal Surgery: A Combined Neurosurgery and Orthopedic Advanced Course, Apr. 5-9, Miami Beach. For information: Dept. of Orthopedics and Rehabilitation, University of Miami School of Medicine, P.O. Box 016960, Miami 33101.

Clinical Management of Coronary Disease and Exercise Testing, Apr. 16-18, Orlando. For information: Charles E. Aucremann, M.D., 7300 Demens Dr. South, St. Petersburg 33712.

Advanced Cardiac Life Support, Apr. 17-18, New Port Richey. For information: James M. Marlowe, M.D., P.O. Box 1058, New Port Richey 33552.

New Developments in Inhalation Anesthesia and Clinical Application in Special Situations, Apr. 24-25, Howard Johnsons Hotel, Pensacola Beach. For information: Warren W. Sears, M.D., 1717 N. "E" Street, Suite 205, Pensacola 32501.

Health Promotion: The Payoff of Business and Industry, Apr. 26-30, Palm Coast. For information: Sue Antonovithz, (219) 392-7151.

Understanding Learning Disabilities in Children, Adolescents and Adults, Apr. 29-30, St. Petersburg. For information: Sylvia O. Richardson, M.D., Dept. of Communicology, CBA 255, University of South Florida, Tampa 32620.

MAY

Third Annual Advanced Cardiac Life Support for Physicians, May 7-8, Cedars of Lebanon Health Care Center, Miami. For information: Debbie Zayas, 1400 Northwest 12th Ave., Miami 33136.

Family Practice Section — Florida Medical Association Meeting, May 8, Hollywood-by-the-Sea. For information: Bernard Breiter, M.D., P.O. Box 1990, Daytona Beach 32015.

Advances in Neonatal and Pediatric Respiratory Care — 8th Annual Seminar, May 16-19, Clearwater. For information: Barbara Anthony, ACH 801 6th St., St. Petersburg.

Master Approach for Cardiovascular Problems, May 29-June 1, Walt Disney World, Fla. For information: Louis Lemberg, M.D., Dept. of Cardiology, University of Miami School of Medicine, Box 016960, Miami 33101.

JUNE

Cardiology for the Practitioner, June 4-11, Mississippi Queen Steamboat Cruise. For information: Lamar Crevasse, M.D., University of Florida College of Medicine, Box J-233, Gainesville 32610.

33rd Annual Scientific Assembly, June 9-13, Fernandina Beach. For information: Guy T. Selander, M.D., 4057 Carmichael Ave., #229, Jacksonville 32207.

Annual Homecoming in Psychiatry, June 11-12, Miami. For information: University of Miami, Dept. of Psychiatry, P.O. Box 016960, Miami 33101.

18th Annual Resident's Day in Ophthalmology, June 19-21, Key Biscayne. For information: Gaby Kressly, Dept. of Ophthalmology, University of Miami, P.O. Box 016960, Miami 33101.

Conference on Reyes Syndrome, June 25, USF College of Medicine, Tampa. For information: Dr. R. Fernandez, 12901 North 30th St., Box 15, Tampa 33612.

JULY

Curso de Medicina Ocupacional (in Spanish), July 12-16, Miami. For information: Dr. Rafael Penalver, Dept. of Office of International Medical Education, P.O. Box 016960, Miami 33101.

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Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid 100 mg.
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Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 5 tablets daily.

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Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neo-



mycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching, it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section). Complete literature available on request from Professional Services Dept. B.M.



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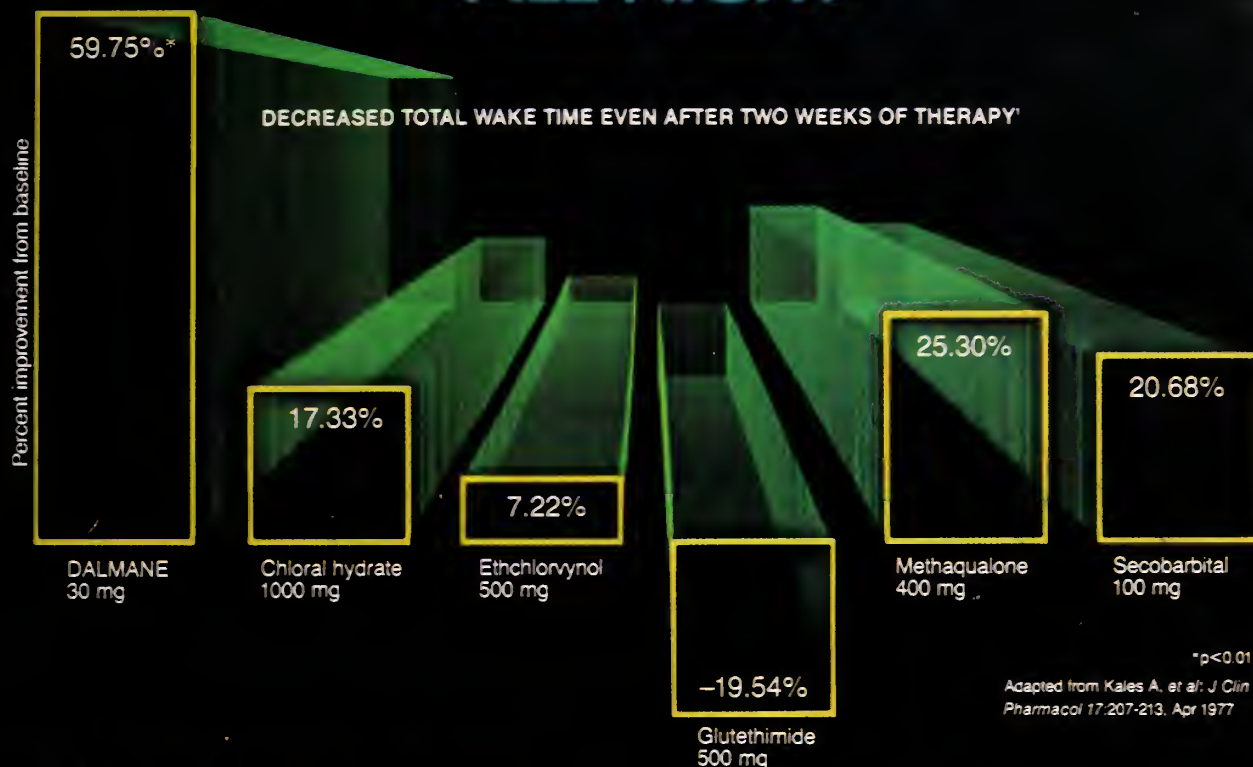
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WITH AN UNSURPASSED RECORD OF EFFICACY AND SAFETY

The efficacy of Dalmane (flurazepam HCl/Roche) has been documented in 185 studies involving 9141 patients suffering from one or more of the three major forms of insomnia—difficulty falling asleep, staying asleep and sleeping long enough.²

Relative safety was demonstrated in a large study of 2542 hospitalized medical patients. Only 3.1% of these patients reported adverse reactions—predominantly unwanted residual drowsiness. None of the reactions were considered serious by attending physicians.³

FOR SLEEP WITHIN 17 MINUTES² AND NO WORSENING OF SLEEP ON DISCONTINUATION

Rapid sleep induction, within 17 minutes on average, sets the stage for insomnia relief. And, after discontinuation of Dalmane for periods ranging up to 14 nights, no worsening of sleep compared with baseline was observed.⁴

Should insomnia recur, the patient may require guidance in setting up a regular sleep program to help

provide the optimum environment for the onset of natural sleep. If hypnotic therapy is required, it should be given for the shortest time at the lowest effective dose to achieve the desired goal.

Consider other medications the patient may be taking (including alcoholic beverages) and be aware of possible drug interactions. Please note that patients should be treated for underlying physical or psychological factors before therapy with a sleep medication is undertaken.

DALMANE[®]
flurazepam HCl/Roche
**THE STANDARD OF HYPNOTIC EFFICACY
FROM THE LEADER IN SLEEP RESEARCH**



Please see reverse side for a summary of product information.



SLEEP-SPECIFIC **DALMANE**[®] flurazepam HCl/Roche

One 15-mg capsule h.s.—recommended initial dosage for elderly or debilitated patients.
One 30-mg capsule h.s.—usual adult dosage
(15 mg may suffice in some patients)

THE STANDARD FOR HYPNOTIC EFFICACY WITH IMPORTANT ADDED BENEFITS

- Well tolerated²
- No chemical interference with many commonly ordered laboratory tests, including triglycerides, uric acid, glucose, SGOT, alkaline phosphatase and total protein^{5,6} (See adverse reactions section of complete product information.)
- Compatible with chronic warfarin therapy; no unacceptable fluctuation in prothrombin time reported^{7,8}

UNLIKE NONSPECIFIC MEDICATIONS USED FOR SLEEP

Tricyclic antidepressants

- which are *not* sleep specific,⁹ yet are sometimes used in nondepressed patients for sleep
- which can cause transient insomnia in the elderly¹⁰
- which can require careful monitoring in cardiovascular patients¹⁰
- which have strong anticholinergic effects¹⁰

Antihistamines

- which are *not* reliable sleep-inducing agents¹¹
- which may produce stimulation instead¹¹
- which have anticholinergic effects¹¹

Major tranquilizers

- whose side effects may be troublesome for nonpsychotic patients¹²
- where tolerance for sedation appears rapidly¹²

Dalmane does not cause significant worsening of sleep beyond baseline levels upon discontinuation.⁴

References: 1. Kales A, et al. *J Clin Pharmacol* 17:207-213, Apr 1977 2. Data on file. Medical Department, Hoffmann-La Roche Inc., Nutley NJ 3. Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther* 21:355-361, Mar 1977 4. Kales A, et al. *Clin Pharmacol Ther* 18:356-363, Sep 1975 5. Moore JD, Weissman L. *J Clin Pharmacol* 16:241-244, May-Jun 1976 6. Spiegel HE. Data on file. Medical Department, Hoffmann-La Roche Inc., Nutley NJ 7. Robinson DS, Amidon EL. Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, pp 641-646 8. Warfarin Study. Data on file. Medical Department, Hoffmann-La Roche Inc., Nutley NJ 9. Baldessarini RJ. Drugs and the treatment of psychiatric disorders, chap 19, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co. Inc., 1980, pp 391-447 10. Cole JO, Davis JM. Antidepressant drugs, chap 31.2, in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore: The Williams & Wilkins Company, vol 2, 1976, pp 1941-1956 11. Douglas WW. Histamine and 5-hydroxytryptamine (serotonin) and their antagonists, chap 26, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co. Inc., 1980, pp 609-646 12. Davis JM, Cole JO. Antipsychotic drugs, chap 31.1, in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore: The Williams & Wilkins Company, vol 2, 1976, pp 1921-1940

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.

Adults: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



ROCHE PRODUCTS INC
Manati, Puerto Rico 00701



In Vertigo

On Balance...

RU-VERT[®]

Each Tablet Contains:

Pentylenetetrazol.	25.0 mg
Pheniramine maleate.	12.5 mg
Nicotinic acid.	50.0 mg

Clinically proven actions

- Antihistaminic
- Cerebral stimulant
- Vasodilator

Few side effects

- Vasodilation occasionally causes facial flushing which can be minimized by recommending that Ru-Vert[®] be taken following meals or with food.

Dosage

- One or two tablets three times a day

Please see next page for a summary of prescribing information

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In Vertigo On Balance... **RU-VERT®**

See following prescribing information.

DESCRIPTION: Each tablet contains the following active ingredients:

Pentylene-tetrazol	25.0 mg
Pheniramine maleate	12.5 mg
Nicotinic acid	50.0 mg

INDICATIONS: Ru-Vert is indicated as an adjunct therapy in the symptomatic treatment of acute or chronic vertigo.

CONTRAINDICATIONS: Convulsive disorders or known history of sensitivity to any of the listed active ingredients. Because of the vasodilating action of nicotinic acid, Ru-Vert should not be used in patients with hypotension.

WARNINGS: The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindications to pentylene-tetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of Ru-Vert who have heart disease. While pentylene-tetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

Pheniramine maleate, like other antihistamines, may produce sedative side effects in certain patients.

Transient vasodilatation due to rapid absorption of nicotinic acid may produce facial flushing and a sensation of warmth. These effects may be ameliorated by recommending that Ru-Vert be taken following meals or with food.

ADVERSE REACTIONS: Pentylene-tetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylene-tetrazol.

DRUG ABUSE: Drug dependence has not been reported with Ru-Vert.

OVERDOSEAGE: Signs and symptoms of acute overdose may be due primarily from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSEAGE AND ADMINISTRATION: The recommended dosage of Ru-Vert for vertigo or motion sickness is 1 or 2 tablets three times a day with meals or light snacks.

This drug is not for use in children under 12 years of age.

HOW SUPPLIED:

Bottles of 100 tablets
Bottles of 300 tablets

NDC 0524-0060-01
NDC 0524-0060-03

Federal law prohibits dispensing without prescription.

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And with our word processing programs, your Commodore computer is versatile enough to be used whenever you'd normally use a typewriter. For memos. Reports. Correspondence. Proposals. In seconds, you can delete, insert, rearrange paragraphs, even revise as many times as necessary. With no time wasted typing multiple drafts.

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FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with three practitioners in solo practice. Major equipment provided. Rent \$250 per month. Competent laboratory and x-ray departments with income based on use. Book-keeping system and receptionist shared. Contact: T. C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

WANTED: NON-INVASIVE CARDIOLOGIST to join well established high caliber internal medicine group in Florida. Private practice affiliated with excellent hospital with stress, nuclear and echo. Lucrative. Delightful location. Contact: C-1068, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST — CARDIOLOGIST: Three man practice seeks badly needed associate with immediate availability possible. Excellent opportunity in well established Internal Medicine, non-invasive Cardiology practice in Coral Gables, Florida. Reply C-1036, P.O. Box 2411, Jacksonville, Florida 32203.

FP NEEDED to associate with two other FPs in office in north Palm Beach County, (Jupiter-Tequesta area). Also space for ophthalmologist, dermatologist or surgeon. Coverage and assistance available. Two open staff hospitals nearby for qualified M.D.s. (305) 746-2033 or (305) 747-0279.

IMMEDIATE OPENINGS FOR ONE FAMILY PRACTITIONER AND ONE INTERNIST: Board certified or eligible for multispecialty association. West coast of Florida, 30 miles north of Clearwater and Tampa. Minimum guarantee with incentive first year, partnership opportunity after first year. Send CV to Michael T. Gossman, Community Health Center, 1150 Plaza Drive, New Port Richey, Florida 33553.

PHYSICIAN NEEDED in emergency clinic located in central Florida. Please call (813) 688-4455 or (813) 685-2288 or send curriculum vitae to: Vinai Artyamsoal, M.D., 3526 South Florida Ave., Lakeland, Florida 33802.

CARDIOLOGIST INTERNIST/ Board certified or Board eligible. Clinical cardiologist to join in top notch internal medicine group in beautiful area. Private practice with hospital affiliation. Stress, nuclear and Echo available. Contact C-1078, P.O. Box 2411, Jacksonville, Florida 32203.

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CARDIOLOGIST INTERNIST wanted for 3-man non-invasive Cardiology/Internal Medicine private practice group in Miami Beach. Excellent hospital affiliations. Board certification in Internal Medicine and recent or current completion of University Cardiology fellowship program required. Send C.V. to: Associates in Medicine, 333 Arthur Godfrey Road, Miami Beach, FL 33140.

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WANTED FAMILY PHYSICIAN ABFP required. Central Florida area. Negotiable terms. To join established physician ABFP. Reply to C-1085, P.O. Box 2411, Jacksonville, Florida 32203.

PHYSIATRIST, REHABILITATION SPECIALIST, full time or part time position is available at a prestigious out-patient physical therapy and rehabilitation center in the Palm Beaches. For inquiry please call or write S. Taylor, The Institute, Building 4000, 210 Jupiter Lakes Blvd., Jupiter, FL 33458. Phone Number (305) 747-2828.

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CARDIOLOGIST-INTERNIST wanted to join group practice in Southeast Florida. Must have interest in Card-Rehab. and Geriatric Medicine. Send CV to C-1086, Post Office Box 2411, Jacksonville, FL 32203.

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UROLOGIST, trained at major New York medical center with one year of pediatric urology fellowship at Toronto. Florida license, available immediately. Call (212) 282-3250.

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INTERNIST, 29, ABIM certified, currently chief resident in Hopkins affiliated program, seeks practice opportunities in central or southern Florida. Will consider group, clinic, or hospital based practice. Reply: William Wood, M.D., 309 Limestone Valley Dr., Cockeysville, MD 21030.

INTERNIST, BOARD ELIGIBLE, American graduate desires group practice in south Florida. University trained with solid general Internal Medicine background plus thorough knowledge of invasive monitoring, assisted ventilation, etc. Contact: Roderick Santa Maria, M.D., 27621 Chagrin Boulevard, Apartment 135, Woodmere, Ohio 44122. Phone: (216) 292-5692.

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Heart Healthy Recipe

BARBECUE SAUCE

1/4 cup water	3 tablespoons Worcestershire sauce
1/4 cup vinegar	1 tablespoon dry mustard
3 tablespoons oil	freshly ground black pepper
1/2 cup chili sauce or catsup	2 tablespoons chopped onion

Combine all ingredients and simmer for 15 to 20 minutes. Good with beef, pork or chicken.

Yield: about 1 1/2 cups Approx. cal/serv.: 1/4 cup = 95
1 tablespoon = 25

Heart Healthy Recipes are from the Third Edition of the American Heart Association Cookbook. Copyright © 1973, 1975, 1979 by the American Heart Association, Inc.



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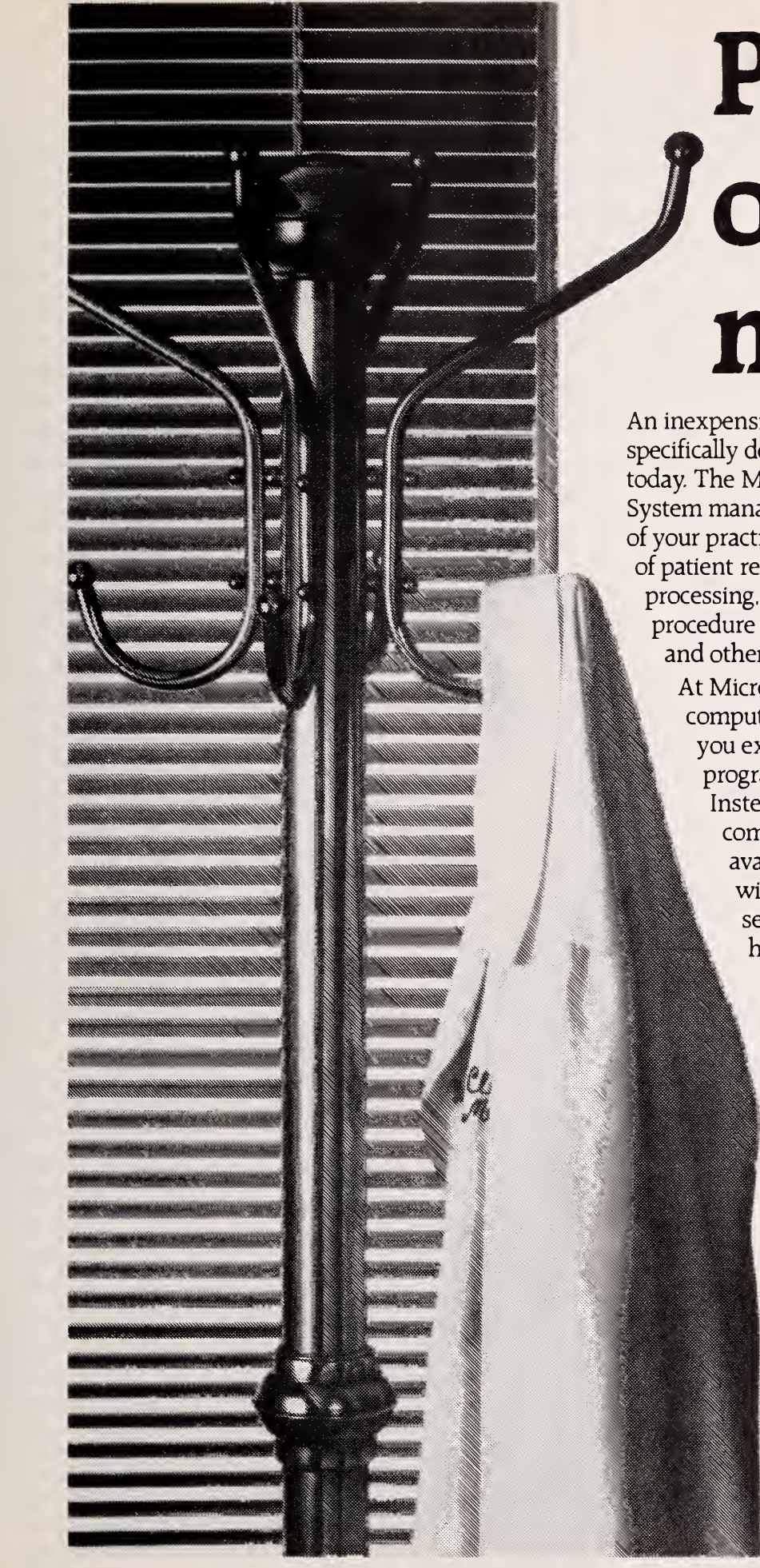
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ONE OF THE VITAL SIGNS OF ANXIOUS DEPRESSION: INSOMNIA

Others to look for:

agitation
anorexia
feelings of guilt
and worthlessness
fatigue
palpitations
headache
vague aches
and pains
sadness
psychic and
somatic anxiety

Artist's conception,
looking out from the human eye
as conceived in a schematic model.

LIMBITROL GIVEN H.S.: ONE OF THE VITAL SPECIFICS OF TREATMENT

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Many patients respond readily to a single bedtime dose of Limbitrol, a convenient schedule that may enhance compliance and helps relieve the insomnia associated with anxious depression. Limbitrol also offers a choice of other regimens: t.i.d., or a divided dose with the larger portion h.s. In all cases, caution patients about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as driving or operating machinery.

in moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline
(as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline
(as the hydrochloride salt)

Specific therapy with h.s. dosage convenience

Please see summary of complete product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses). Myocardial infarction and stroke reported with use of this class of drugs. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated. Sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecostomia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, olopecio, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine mesylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50.

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U. S. ARMY MEDICAL DEPARTMENT
First Year Graduate Medical Education
General

The Army Medical Department (AMEDD) operates the largest unified Graduate Medical Education (GME) program in the United States and probably in the free world. The AMEDD is one of the most mature educational systems in America. The AMEDD's purpose is to conduct quality GME in accredited programs of the specialties and numbers needed to produce a Medical Corps composition and strength that is appropriate to the needs of the total Army. Programs are conducted at all eight medical centers and at five community hospitals (Forts Benning, Belvoir, Bragg, Hood and Ord), but through outreach programs from these parent facilities many other Army hospitals are involved with residency training. All Army medical training programs are approved by the Council on Medical Education of the American Medical Association. Virtually all recognized residencies are offered. Each Army training hospital is affiliated with a leading nearby medical school. The range of cases, both in complexity and age, is virtually impossible to duplicate and medical records keeping is excellent. The well trained and competent ancillary support staff of an Army Hospital allows residents to spend a majority of their time treating patients, not doing chores. Also, we have designed our programs to ensure that our residents are used as full-time doctors—not part-time, tag-along onlookers. Total patient care responsibility is stressed.

Application

During the summer of 1983 the AMEDD will offer approximately 350 First Year Graduate Medical Education (FYGME) positions. Historically, most positions are filled by medical school graduates who were Army scholarship participants. However, the AMEDD actively seeks highly qualified civilian student applicants who have no current affiliations. FYGME programs are available in the flexible, categorical and categorical diversified categories.

Deadline for applications is 1 September 1982. All applicants are encouraged to also participate in the NIRMP. Selections for the Army FYGME Program will be announced in sufficient time for selectees to withdraw from the NIRMP.

To find out more information concerning this program, the eligibility criteria, service obligation, benefits, and application procedures contact:

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- **only a 60% cure rate with penicillin V-K**



As seen on admission



After one week of penicillin V-K therapy



Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. No treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

Brief Summary of Prescribing Information

TEGOPEN®
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular

(12) 9/11/75

INDICATIONS

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but no failures with Tegopen.

		Given Tegopen® (cloxacillin sodium)	Given penicillin V-K
<i>Staphylococcus aureus</i>	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
<i>Staphylococcus aureus</i> and <i>Streptococcus pyogenes</i>	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth	(14 patients)	9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic <i>Streptococcus</i>	(1 patient)	0	1
TOTALS:	102 patients	52 patients	50 patients

†Eleven patients did not return for their one-week checkup. These were all called by telephone and their families reported

the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus*, 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes*, and 1% beta-hemolytic *Streptococcus*.†
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.

- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

†The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®

(cloxacillin sodium)

—effective therapy for staph infections of the skin and skin structures

WARNING:

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:

The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:

Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose

stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:

Adults: 250 mg. q. 6h.

Children: 50 mg./Kg./day in equally divided doses q. 6h. Children weighing more than 20 Kg should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B. INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

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Capsules—250 mg. in bottles of 100 500 mg. in bottles of 100
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COVER

The cover this month features aging as presented through a child and his grandfather. *The Journal* is grateful to Mrs. Ruthe Dawes of Atlantic Beach for allowing us to use her painting on the April cover.

Subscription Rate: \$15.00 per year, single copy, \$1.50 (plus 4% sales tax within State of Florida except special issues which are \$2.50 plus tax.) Address: The Journal of the Florida Medical Association, Inc., P.O. Box 2411, 760 Riverside Avenue, Jacksonville, Florida 32203. Telephone (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

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**When painful spasm
is the presenting
symptom...**

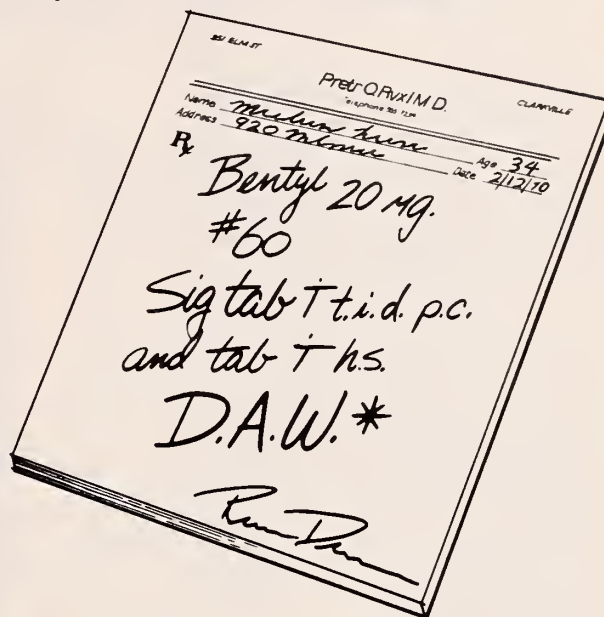


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Bentyl[®]
(dicyclomine hydrochloride USP)

10 mg capsules, 20 mg tablets,
10 mg/5 ml syrup, 10 mg/ml injection



**D.A.W.-Dispense as written*

because:

- ⊕ The Bentyl molecule is a product of original Merrell research.
- ⊕ At Merrell Dow, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- ⊕ Bentyl bioavailability of tablets, capsules, syrup and injectable is evidence of its prompt absorption.
- ⊕ Bentyl helps control abnormal gastrointestinal motor activity with minimal anticholinergic side effects. (See Warnings, Contraindications, Precautions, and Adverse Reactions on next page.)
- ⊕ The bioequivalence of the oral dosage forms permits a choice of tablet, capsules, or syrup that satisfies patient's dosage preferences.
- ⊕ Significant pharmacologic effect in the distal colon compared to placebo,¹ shows how Bentyl controls abnormal motor activity in the irritable colon patient.*

*This drug has been classified "probably" effective for this indication.

Merrell Dow

Reference:

1. Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

Although the dose of Bentyl used to show pharmacologic effect was 50 mg, which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg (2 ml) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®**(dicyclomine hydrochloride USP)**

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia, urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis, urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.

DOSEAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg capsule and syrup. *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily (Dilute with equal volume of water).

Bentyl 20 mg: *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by

CONNAUGHT LABORATORIES, INC.

Swiftwater, Pennsylvania 18370 or

TAYLOR PHARMACAL COMPANY

Decatur, Illinois 62525 for

Merrell

MERRELL DOW PHARMACEUTICALS INC.

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Professional liability — a problem for all of society

Medical professional liability has become more than a problem for the medical profession. It has become a problem which will require the efforts of all of society to resolve. The rapidly escalating number of suits alleging medical professional malpractice and the rapidly increasing level of settlements and awards to plaintiffs in such suits is reaching a level at which the medical profession will no longer be able to provide adequate funds for paying the claims. The present system will become bankrupt and there will no longer be a mechanism to take care of the legitimate needs of individuals who have been harmed by inadequate or inappropriate medical care.



At the outset it should be pointed out that every responsible individual in the medical profession believes that anyone who has a problem arising as a result of improper medical care should be compensated in an appropriate manner to lessen and, whenever possible, eliminate the problem caused by such inappropriate medical care. There is deep concern by these same responsible physicians that the suffering of an individual harmed by poor medical care might result in a financial windfall to relatives and to attorneys.

It should also be noted that the FMA is involved in an ongoing program of continuing medical education for practicing physicians in order to be certain that its members are kept up to date professionally. The FMA and all components of the federation of medicine — state and county medical societies and specialty groups — have a commitment to improve standards of health care and to remove incompetent practitioners from the field of medicine.

It is paradoxical that, at a time when the quality of medical care is improving at a rate faster than ever before in the history of man, the suits against doctors are increasing in the same rapid fashion. Doctors are now being sued for the results of their treatment of

injuries and illnesses by patients who, a few years ago, would never have survived these injuries and illnesses.

The American medical profession has reached a level of scientific and technical excellence that has never before been present in any group of individuals in the history of the world. Admission to medical school is a goal to which many aspire but few are selected. Those selected achieve this distinction only by virtue of an extraordinary demonstration of academic and personal achievement. Virtually every family in our country would be delighted and honored if one or more of its daughters or sons are selected for admission to an American medical school. With the usual period of education, including four years of college, four years of medical school and three to five years of specialty training, the young doctor going into practice has qualifications that assure professional competence. These young doctors, constituting the best our society can produce, are the linchpin of health care in our country.

The privilege of these highly trained professionals to practice medicine for the benefit of all Americans is being threatened by the debilitating effects of professional liability with professional liability insurance premiums reaching well over \$20,000 per year in many instances and current projections indicating that insurance premiums in excess of \$50,000 per year are soon to be confronting medical practitioners. It must be pointed out that the doctors in active practice today, approximately 350,000, are not in a position to guarantee perfection of results for every individual who becomes ill or injured and needs medical care. Yet the public is becoming unwilling to accept anything less than perfection in their medical care.

The public must realize that the primary source of dollars to pay for the professional liability insurance premium is from the patients who are served by the doctors. There is no unlimited source of funds to take care of real or imagined harm following medical care. The public should be made aware that many lawyers are becoming wealthy because of imbalances in the present system of compensating individuals in professional liability cases.

Although medicine is far from perfect, medical education and practice in the United States has led to

standards of medical care which were only dreams two or three decades ago. This level of medical care has developed primarily through the efforts of the free enterprise system, with generally reasonable regulatory restraints by governmental bodies, primarily at the state level, and financial support from the federal and state governments and private foundations. This complex system is now being threatened by the spectre of professional liability insurance costs which may become so high that they can only be funded by the federal government. Most thoughtful individuals believe that, if the full program of medical education and practice becomes exclusively a governmental activity, the standards of medicine can only be lowered and the continuing advancement of medicine will be slowed materially. One has only to look at the effects of governmental intervention in many of the European countries to see what happens when the government has complete control.

There is no readily apparent simple solution to the problem. A comprehensive article on this subject was published in the November 1981 issue of *The Journal of the Florida Medical Association* (JFMA 68: 908, 1981). This will provide an excellent background for an understanding of the role of the FMA in professional liability. One mechanism for improving the situation is by action of the Florida Legislature. Legislative activity can do much to provide tort reform which can help to bring some reasonableness into the problems of professional liability.

The 1983 efforts of the Florida Medical Association in the legislative field will be primarily directed toward improvement in the professional liability status of the practice of medicine in Florida. Because of other major problems confronting the 1982 Legislature and because there had been so much effort in the field of professional liability in recent legislative sessions, consultants and others knowledgeable in the legislative arena advised against any significant effort in professional liability legislation by the FMA during the 1982 session.

In order to have a Legislature which will be responsive to the problem and give careful consideration to the proposals of the Florida Medical Association, it is essential for the medical profession to become involved in the political process of electing the Legislature. Many doctors have felt that their only responsibility as citizens is in their practice of medicine and that political activities are somehow beneath their dignity. Nothing could be further from the truth. It is imperative for doctors and members of their families to become involved in the political process of electing candidates to the Legislature in the fall of 1982. The members of the Legislature in 1983 will be made up primarily of those who were elected in the fall of 1982. Those who have had adequate support by the medical profession will be much

more likely to give proper consideration to the proposals of the Florida Medical Association.

FLAMPAC has been established by the doctors of Florida to engage in the political process of electing state legislators and other public officials. This has been a very effective organization and it is extremely important for doctors and their families to give support to FLAMPAC and to become involved with individual candidates so that proper candidates can be elected to office. Without a responsive Legislature in 1983 there seems to be little hope that tort reform and other legislative remedies can be developed so that the crisis in professional liability can be alleviated.

It is necessary for doctors of medicine to speak to the Legislature concerning professional liability with a single voice. Splinter groups can only dilute the effectiveness of organized medicine. All concerned doctors and their families are urged to work in FLAMPAC and through the legislative council of the FMA in helping to get appropriate state legislative changes in the field of professional liability in 1983.

Sanford A. Pullen, M.D.



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Cutlass/Regal	247.00 per month	Mercedes, 240 Diesel	424.61 per month
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BMW-320i	341.00 per month	Mercedes, 380 SL	897.72 per month

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Sanford A. Mullen, M.D.

Sanford A. Mullen, M.D.
President, Florida Medical Association

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That's important. And unusual. Group term life insurance coverage by its very purpose and nature terminates or drastically diminishes when you retire. And the cost of continued coverage can be prohibitive. The FMA-sponsored Wraparound Retired Lives Reserve, on the other hand, picks up coverage on a pre-paid basis *even after you retire and stop paying premiums.*

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High-value continuing coverage and tax-deductible premiums are obvious advantages. But there's more. Consider also that your post-retirement coverage provides a potential source of income-producing assets to your estate for your heirs. And the surety of a solid estate base allows you the option of converting other policies to annuity status for additional retirement income.

For FMA members only.

The FMA-sponsored Retired Lives Reserve is restricted to member physicians and their staffs.

No medical examination.

A medical examination is not required for eligibility.

Get the facts.

Space does not permit all of the outstanding benefits of the Wraparound Retired Lives Reserve program to be listed here. The FMA and MAPS urge you to acquaint yourself with the numerous benefits of this customized Retired Lives Reserve program. Mail the attached postcard to arrange a confidential appointment with a MAPS representative to see what this innovative plan can mean to you.

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I'd like to assess how the FMA-sponsored Retired Lives Reserve fits into my financial situation. Please have a MAPS representative call to arrange a mutually convenient appointment. No obligation, of course.

Name

Address

City

State

Zip

Home Phone

Office Phone

Best time to call

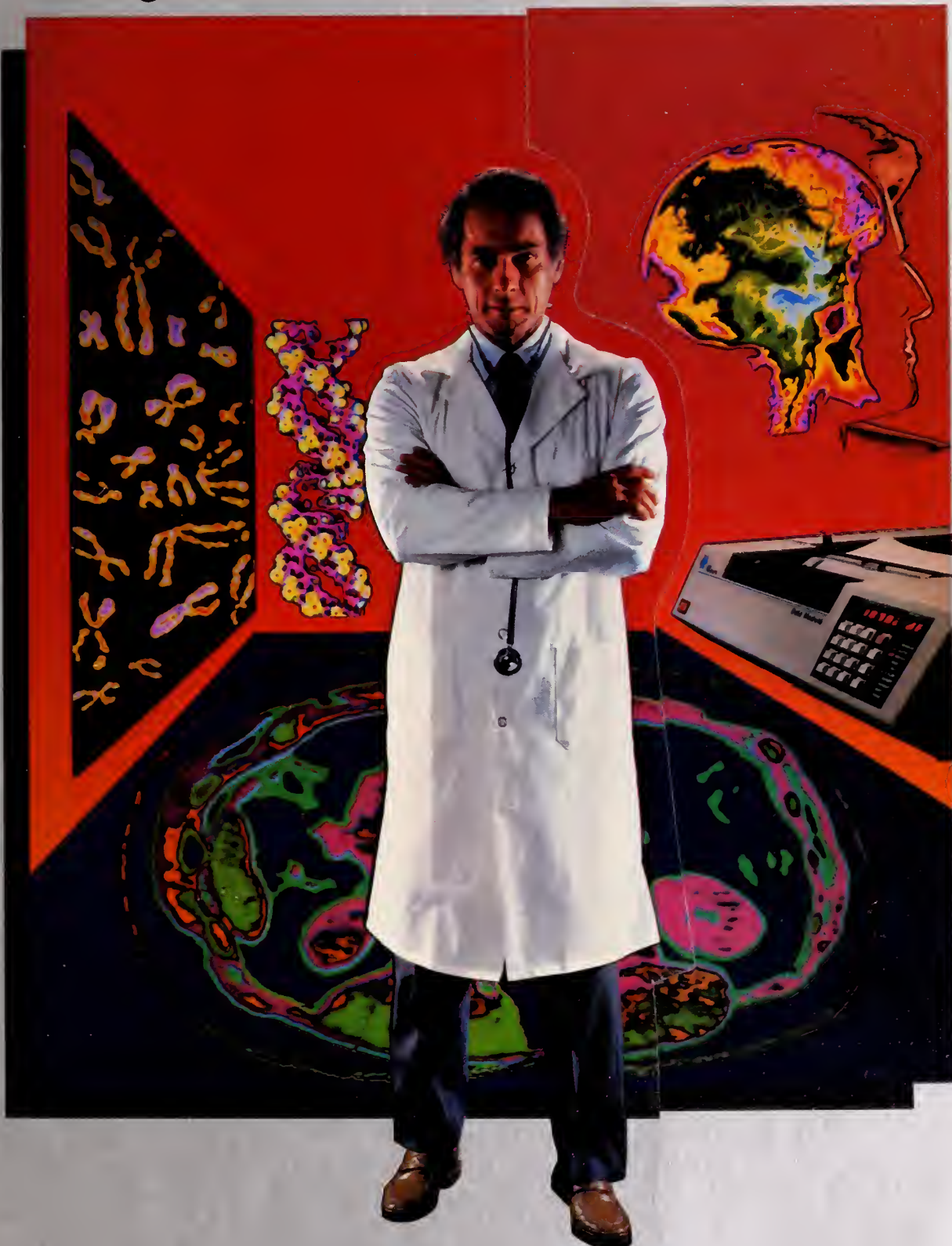
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a.m.

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In an era of change,
An Agent of Change...



Ativan®: Agent of Change (lorazepam)

Your patients are changing

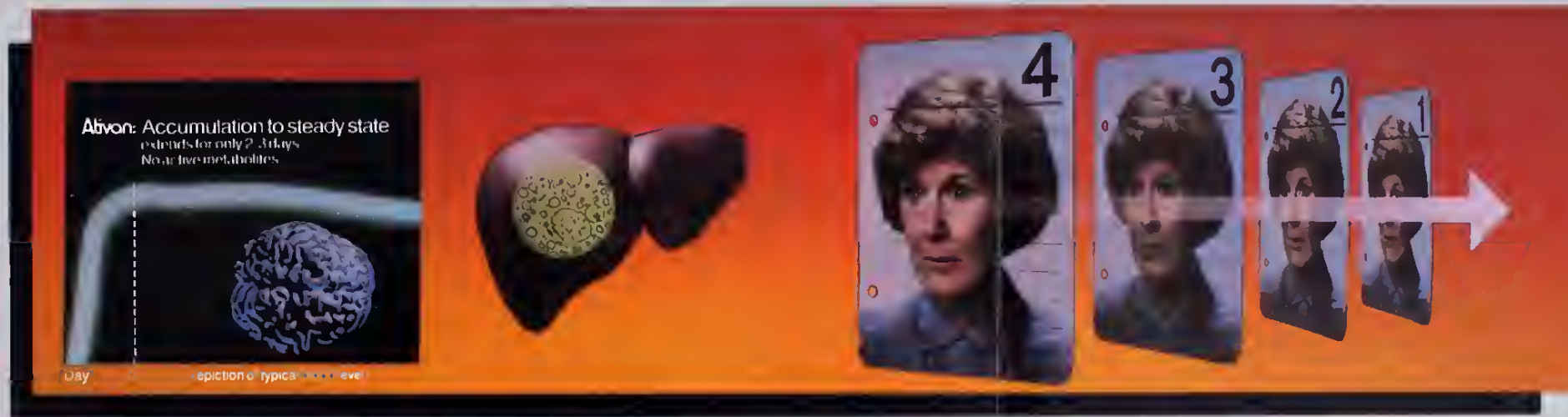
the population is getting older, more people are holding a second job, patients are more concerned about the medications they take

Medical knowledge is changing

there are diagnostic resources and surgical techniques undreamed of only a few years ago, biomedical engineering, new insights also into the action of drugs

In this changing environment, the way you are practicing medicine is changing too...

Twenty years ago, the benzodiazepines represented a real step forward in the management of anxiety and tension states. In recent years, however, concern about drug accumulation and clearance has led physicians to re-evaluate their use of these agents. In light of current knowledge, many clinicians are changing from multi-metabolite benzodiazepines to Ativan® (lorazepam)—a metabolically and pharmacokinetically distinctive agent that offers clinical advantages which more closely meet the expectations of a modern anxiolytic.



because...

it's shorter acting, with less accumulation*


In contrast to long-acting benzodiazepines, Ativan has a short, 12-hour half-life, and no active metabolites. In multiple-dose therapy, Ativan accumulates for only two to three days before reaching steady state; the long-acting benzodiazepines—diazepam CIV, chlordiazepoxide CIV, clorazepate CIV and prazepam CIV—with their active metabolites—accumulate for as long as 20 days, increasing the likelihood of excessive sedation.

it doesn't interact with drugs metabolized by P450 microsomal enzymes

Most benzodiazepines undergo oxidative metabolism and thus utilize the hepatic microsomal enzyme system. Ativan® (lorazepam), however, is metabolized by glucuronidation and does not compete with other drugs for cytochrome P450. Thus, when Ativan is given with Tagamet® (cimetidine), for example, clearance is not delayed, nor sedation increased*—unlike reported observations with patients on other benzodiazepines¹⁻⁵

it gives you greater control of therapy

The short half-life of Ativan® facilitates more rapid response to dosage adjustments, allowing you to titrate therapy to patients' changing needs. Also, once you decide to discontinue Ativan, it will be out of your patient's system four days after the final dose—in contrast to long-acting benzodiazepines and their active metabolites which take as long as two weeks to be totally eliminated.

Ativan®
for (lorazepam) 
Anxiety

See important information on following page

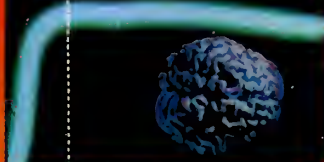
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2. Desmond PV, Patwardhan RV, Schenker S, et al. Ann Intern Med 93:266-268, 1980
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*Pharmacokinetics cannot as yet be directly related to efficacy
*All benzodiazepines produce additive effects when given with CNS depressants such as barbiturates or alcohol

Ativan®: Agent of Change

(lorazepam) 

Ativan: Accumulation to steady state extends for only 2-3 days
No active metabolites



Day 3 depiction of typical blood level



- Little accumulation lessens likelihood of excessive sedation
- Unlike most benzodiazepines, Ativan does not compete with other drugs, such as Tagamet® (cimetidine), for the microsomal enzyme system during biotransformation
- Metabolism not affected by age or liver dysfunction
- Short half-life provides greater control of therapy
- Promptly eliminated from patient's system after discontinuation
- Specifically evaluated and found effective for anxiety associated with cardiovascular and gastrointestinal disorders
- A distinctive change from long-acting benzodiazepines, all of which have active metabolites and are much the same

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Dosage: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

How Supplied: 0.5, 1.0 and 2.0mg tablets.

Wyeth Laboratories Philadelphia, PA 19101



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Summary of the FMA Board of Governors Meeting March 13, 1982

The following is a summary of the major actions taken by the Board of Governors at its meeting, March 13, 1982 at the Host International Hotel, Tampa, Florida.

Council and Committee Reports

Reviewed the Report and Recommendations of FMA Councils and Committees and took the following actions:

COUNCIL ON LEGISLATION

Funding of HSA's

Approved a position of 'active opposition' to the Health Systems Agencies bill (CS/SB 683) due to provisions which expand authority of HSA's by creating 'coalitions for promotion of competition in health care,' and to fund these by means of a Certificate of Need filing fee.

Financial Disclosure

Approved a position of 'opposition' to the Disclosure of Physician Financial Interest in Health Care Facilities (SB 380, HB 733).

Health Planning

Endorsed legislation establishing by statute a local health planning program to replace the current Health Systems Agency (HSA) program, and to establish a Florida task force on competition and deregulation in health care, with equitable representation for physicians. The functions of such a task force would be to:

- Encourage cost effective approaches to the delivery of health services and control wasteful or abusive practices on the part of government, labor, business, providers and the public at large.
- Evaluate existing programs and proposed programs and make recommendations to the Governor and Legislature on ways to stimulate price and service competition among health care providers and insurers.

- Recommend to the Governor and Legislature a comprehensive program(s) to encourage healthful lifestyles that will limit the need for future medical care.
- Evaluate existing public sector regulations of the health care industry for the purpose of recommending to the Governor and Legislature ways in which regulations can be eliminated, streamlined or altered in order to assure access to quality care at a reasonable cost.
- Recommend to the Governor and Legislature ways in which they can initiate and/or support the development of voluntary business health coalitions.
- Evaluate changes in federal policy and legislation relating to health care costs and develop recommendations for action by the state of Florida in order to cope with these federal changes.

COUNCIL ON SPECIALTY MEDICINE

Specialty Group Recognitions

Approved continuing recognition for 36 of FMA's 38 currently recognized specialty groups which includes representation on the FMA Council on Specialty Medicine. Two specialty groups have not yet met the criteria for receiving continuing full recognition.

Guidelines for Recognition

Approved modifications to the guidelines for the FMA program for recognition of specialty groups:

- Abolish the status of 'provisional' under the FMA recognition program guidelines for the specialty recognition program. There will be only two categories for recognition — full and probationary.

- Include under the category 'probationary' any deviation in excess of 10% from guidelines I. H.; and further, that any specialty group placed in the probationary category, while retaining all rights of participation in deliberations of the Council, will be denied the privilege of the vote during the year of probation.
- Provide that FMA terminate a specialty from the program if it does not satisfy the guidelines set forth by the FMA for recognition at the end of a probationary status; however, the specialty may reapply and begin as a new specialty.
- Change the timeframes for the specialty recognition program to biannual review on an alternating basis, and further that this alternating program be implemented beginning in 1983 with an odd/even numbering system with the odd numbered reviews completed for presentation by the FMA Annual Meeting in 1984 and the even numbers reviewed in 1985.

Treatment of Aphakia

Adopted a resolution from the Florida Society of Ophthalmology regarding the treatment of the eye condition of aphakia by non-medical practitioners.

RESOLVED, That new separate procedure codes pertaining to those services provided by non-medical practitioners (optometrists) for the condition of aphakia be developed to distinguish from those services provided by physician providers (ophthalmologists) for the treatment of aphakia; and be it further

RESOLVED, That accurate descriptive terminology be developed to reflect the extent of the limited services provided by the non-medical practitioner (optometrist) for the condition of aphakia; and be it further

RESOLVED, That the Florida Society of Ophthalmology requests that the Florida Medical Association adopt this resolution for establishment as a policy of the Florida Medical Association and to take all necessary action to see that the intent of this resolution is implemented.

COUNCIL ON HEALTH CARE FINANCING

PMUR Contract

Adopted a position that the terms of the proposed contract between the Florida Medical Foundation and Blue Cross/Blue Shield of Florida for the Foundation to provide peer medical utilization review for Medicare includes inadequate reimbursement for physicians providing review. However, because of the importance that PMUR be performed by physicians,

Health Care Competition

HMO's

Resolution 81-10 Discriminatory Reimbursement by Medicare

the Board approved the 1982 contract with continuing participation in the program by FMA component county medical societies.

*Approved for submission to the House of Delegates a proposed FMA policy statement on health care competition.

*Approved for transmittal to the House of Delegates a status report on health maintenance organizations to be used as an FMA resource document.

**To be included as enclosures with the Delegates Handbook.*

The Resolveds of this resolution, introduced by the Seminole County Medical Society at the 1981 House of Delegates, called for the FMA to petition the Florida Legislature to bring about an end to the gross inequity between the fees paid urban and rural physicians for Medicare in the state of Florida.

The Board approved a recommendation that the appropriate agency to be approached in carrying out the intent of the resolution was the Health Care Financing Administration of the federal government through the Medicare carrier, Blue Cross/Blue Shield of Florida. A petition has been filed to correct any existing fee inequities as stated in the resolution.

Redwood Health Foundation

Authorized a study of the approach taken by the Redwood Health Foundation in California in providing care to Medicaid recipients with particular respect to potential application in Florida.

COUNCIL ON SCIENTIFIC ACTIVITIES

Accreditation Council for Continuing Medical Education

Approved a recommendation that FMA seek to obtain the appointment of a practicing physician from the southeastern United States to the Accreditation Council for Continuing Medical Education.

FLAMPAC

Board of Directors

Approved the appointment of Dr. Robert E. Windom, FMA President-Elect, as a regular member of the FLAMPAC Board of Directors and Mrs. Nancy Corwin of Jacksonville as an additional Auxiliary member to the Board. Dr. Luis M. Perez, FMA Secretary, was appointed as the FMA Board of Governors representative on the FLAMPAC Board.

1984 FMA Annual Meeting

The Board directed that the 1984 Annual Meeting of the Association, May 2-6, be held at Lake Buena Vista, Florida subject to satisfactory arrangements.

	<p>The Board received a report that as a result of expanded development of hotel facilities in the Lake Buena Vista area due to the current development of EPCOT, it appears that adequate facilities will be available in the near future for holding the Annual Meeting in that area, and it would be feasible to plan to hold the FMA Annual Meeting in Lake Buena Vista in 1984.</p>	
School Health Conference	<p>Authorized FMA co-sponsorship of the School Health Conference scheduled to be held in Sarasota, November 17-19, 1982.</p>	<ul style="list-style-type: none"> Retired doctors may continue their health insurance until age 65. If less than 65 and/or eligible for Medicare, they may cancel their health insurance; and we can write a Medicare wraparound policy.
Southern Medical Association	<p>Approved FMA co-sponsorship of the Southern Medical Association Medical Staff Leadership Conference in Orlando, June 10-11, 1982.</p>	<ul style="list-style-type: none"> Persons who are currently disabled or not working at the time they apply for insurance coverage are ineligible to join the program until they resume full-time work; full time being 20 hours per week for health insurance, and 30 hours per week for life insurance.
FMA Student Medical Association	<p>Enthusiastically approved for submission to the House of Delegates a proposal for the establishment of the Florida Medical Association Student Medical Society. (To be included as an enclosure to the <i>Delegates Handbook</i>.)</p>	<ul style="list-style-type: none"> Physicians who have attained the age of 65 are not eligible for the \$50,000 extra or optional life insurance over the basic \$50,000. Physicians who are currently over age 65 and carrying \$100,000 worth of life insurance must have their coverage reduced to the basic \$50,000.
Resolution 81-11 Seating Delegates	<p>This resolution, introduced by the Hillsborough County Medical Association at the 1981 House of Delegates, was referred to the Board of Governors for an appropriate amendment to the FMA bylaws to carry out the intent of the resolution.</p> <p>The Board approved an amendment to the bylaws for submission to the House of Delegates allowing for seating of alternate delegates during sessions of the House of Delegates.</p>	<ul style="list-style-type: none"> Effective June 1, 1982, the basic \$50,000 life insurance will be reduced to 65% of the face amount between the ages of 65 and 70 if the physician is still working. All life insurance coverage is to terminate at the age of 70.
Florida Medical Insurance Trust	<p>Approved a proposed clarification to the FMIT program for retired physicians:</p> <ul style="list-style-type: none"> Retired doctors cannot continue their group life insurance beyond the date of their retirement. They have a right to convert to a plan offered by American Heritage Life Insurance Company. 	<p>1982 Meeting Dates</p> <p>Approved a change in the dates for the Board of Governors Meeting scheduled to be held May 28-30, 1982 to June 4-6, 1982.</p> <p>Council and Committee Annual Reports</p> <p>The Board reviewed the Annual Reports of FMA Councils and Committees as well as resolutions from county medical societies received to date which will be included in the <i>Delegates Handbook</i> that will be mailed to all delegates and alternate delegates for review at least 30 days in advance of the FMA Annual Meeting, May 5-9, 1982.</p>

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Rosenthal and Leibman studied 23 pediatric patients with diarrhea. All had one or more negative stools. Of these, 5 patients had *Giardia lamblia*

which was diagnosed by the simple ENTERO-TEST® procedure. Lopez and co-workers diagnosed Giardiasis in 22 patients with the ENTERO-TEST® compared to 4 patients by stool exams. ENTERO-TEST® has proved to be a useful and effective method for the localization of upper GI bleeding, and the diagnosis of Typhoid carriers, strongyloidiasis and other parasitic diseases.

References:

Rosenthal, P., and Liebman, W.M: Comparative study of stool examinations, duodenal aspiration, and pediatric Entero-Test for giardiasis in children. *J. PEDIAT.* 96: 278 (Feb.) 1980.

Thomas, G. E., et al: Use of the Entero-Test duodenal capsule in the diagnosis of giardiasis. *South Afr. Med J.* 48: 2219, 1974.

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Gilman, R. H: Identification of gall typhoid carriers by a string bladder device. *The Lancet*: April 14, p. 795, 1979.



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Brief Summary.

Consult the package literature for prescribing information.

Indications and Usage: Cefclor* (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip USP, Lilly).

Usage in Pregnancy:—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy:—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefclor.

Hypersensitivity reactions have been reported in about 1.5

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

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percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefclor* (cefclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain:—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic:—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic:—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal:—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). (1002818)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

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5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II 880. Washington, D.C.: American Society for Microbiology, 1978.
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7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.
Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

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A new look for The Journal

Approximately two years ago, the editors undertook a study to evaluate the design of *The Journal* in terms of consistency of orderliness and coherence of component parts as well as overall visual appeal. In the course of this study, it was readily apparent that for many years there had been numerous changes with concomitant alterations in makeup, design and format.

Consequently, the editors sought to remedy the problems by exploring the possibility of effecting a complete redesign of *The Journal* in keeping with current journalistic trends. The project began with a survey of available talent in the graphic design business. After careful deliberation, the editors procured the services of Paul Fisher, Ph.D., an eminent professor of journalism at the University of Missouri and a national authority in the field of typography. The selection of Professor Fisher seemed particularly appropriate since he has conducted several workshops throughout the country for editors of both state and county medical journals.

He has been one of the judges in the Annual Medical Journalism Awards Contest sponsored by Sandoz, and in 1979 and 1981 he was the guest speaker for the annual joint meeting of the FMA Committee on Scientific Publications and the JFMA Board of Consulting Editors. In the contractual arrangement with Professor Fisher, the editors purposely did not impose any restrictions on his work. Thus, nothing in *The Journal* was considered untouchable.

The completed package or "Fisher Proposal" was scrutinized first by the executive editorial staff of *The Journal*. It was then reviewed by the full Committee on Scientific Publications, following which recommended changes were presented to the Board of Governors for final approval. Not all of the "Fisher Proposal" was accepted as presented. For example, the two-page format containing the names of editors and the contents of *The Journal* is a revision of the originally suggested one-page format. Also contrary to the proposal, the editors elected to preserve a separate page each for the President's Page and the editorials.

The changes in design initiated with this issue are obvious from the front cover to the back. Two new type faces have been introduced. The text type is

called Medieval Roman, and the headline type is named Olive. The cover illustration is always to be square with precise dimensions. Moreover, the first page of every scientific article emphasizes title, author, abstract, author information and the first part of the text. Run-in subheadlines in bold face type replace those traditionally centered above occasional paragraphs.

As the reader can readily discern, the changes are numerous. The editors sincerely hope that in the aggregate this "new look" for *The Journal* will present a more interesting and appealing reading package.

Daniel B. Nunn, M.D.
Editor

The aging physician

Respect and even reverence for the aged has been a theme for most civilized people. In our own profession Hippocrates, Galen and Osler have usually been portrayed as old men when at the height of their prominence.

There is no doubt that this concept has been eroded by the great technical advances in medicine in many instances requiring vigorous skills which tend to leave behind the more mundane pragmatic practitioner of the art.

As a general practitioner, I have set a chronological age at which to stop the more intricate and stressful procedures. I stopped obstetrics at age 60 and began restricting surgery at 70.

The younger generation of physicians in justifying their choice of the more sophisticated specialties is apt to repeat the modern aphorism that it is impossible any longer for an individual to keep abreast of the modern advances in medicine.

I'm afraid the wonderful and amazing advances are largely technical and have the tendency to blunt our native diagnostic acumen to such an extent that we are more apt to limit our horizons because of mental laziness instead of inability to grasp new discoveries. This is certainly true in internal medicine. In surgery, the great advances in anesthesiology, equipment for surgical diagnosis and supportive therapies make our operations much easier. No longer is it necessary to try for lightning speed and no longer does the number of exploratory procedures exceed the number of well-planned ones.

The aged physician may lose judgment enough that he is unable to recognize his own ability to practice good medicine. Every county medical society now has a committee to help impaired physicians and

protect the public. We, the elderly, are actually relieved that we have such a monitor.

The public is protected to some extent by most hospital bylaws. Yearly reassessment of qualifications of the staff is required by most hospitals. Renewal of privileges depends on peer review of each physician's competence and he must reapply for specific procedures. Also, most hospitals are now requiring a yearly or bi-yearly appraisal of the physician's physical and mental health. This last provision *must* be emphasized in all physicians, particularly those over 65 or with demonstrated problems. This particular category should be passed on by a staff-appointed team rather than allowing the staff member to fill his own form.

The elderly physician who keeps his interest in hobbies, athletics and sports, in general, is doubly fortunate. One who continues involvement in local community, medical and national affairs can make his old age a happy culmination of earlier struggles and disappointments.

When asked if I would like to be young again, I always answer *no*. I am having the time of my life. The careers of my children, practically all of whom have either chosen the medical field or a related one, are an improvement on my own and for the most part are insuring their own happiness by developing a weltanschauung hardly possible in my day.

My interests are indeed still diverse and for the first time in my life, I am able to indulge them. The elderly physician in the vernacular *ain't never* had it so good!

H. L. Harrell Sr., M.D.
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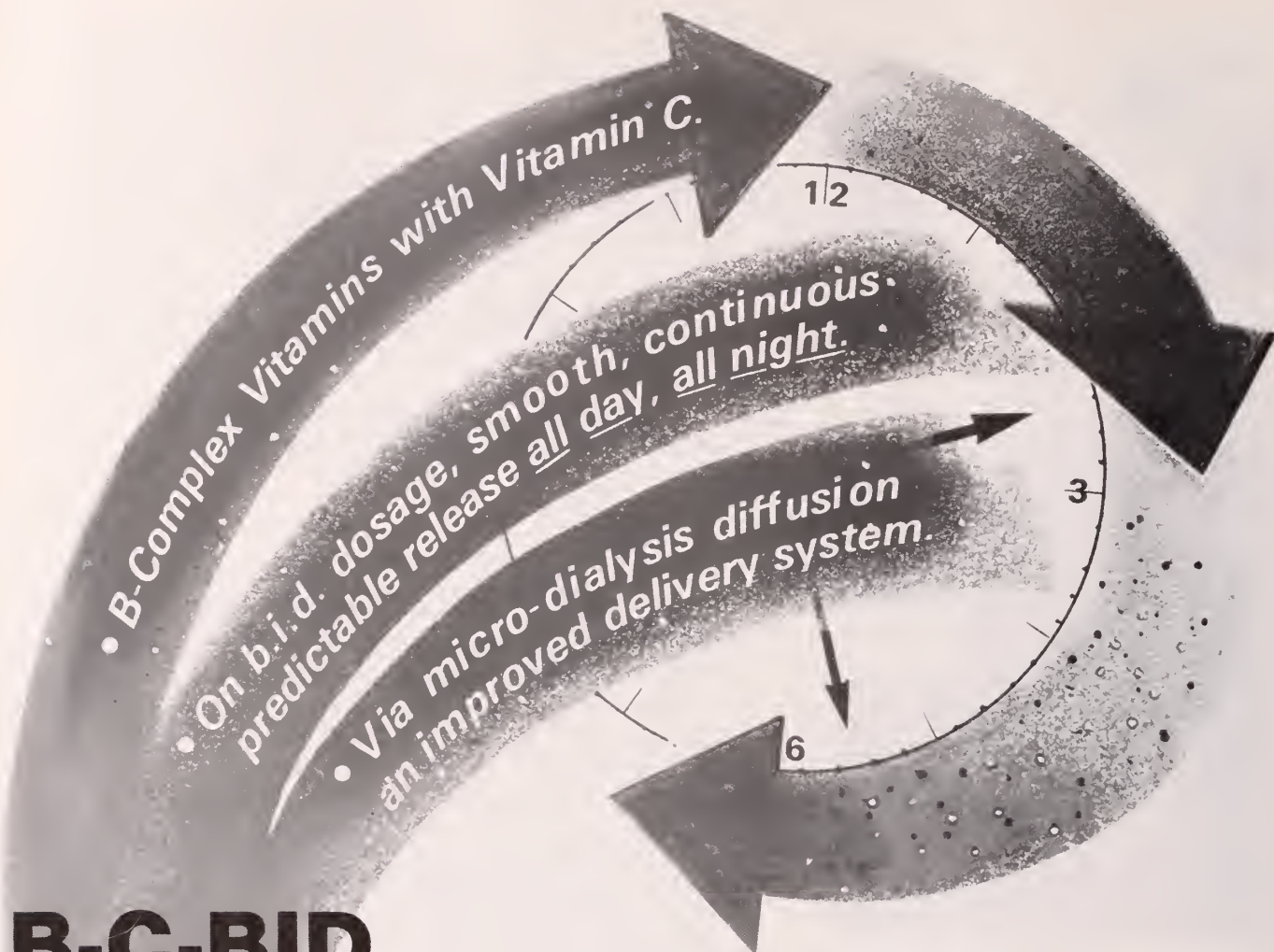
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Guest editor's introduction

The process of aging

Lee A. Fischer, M.D., P.A.

The Process of Aging is the topic addressed in this special issue of *The Journal* and the theme of the Florida Medical Association Annual Scientific Session May 5-9, 1982 in Hollywood, Fla. The editors wish to thank the many authors who submitted papers for this issue. We attempted to select articles of general interest to the membership, rather than focus on specific illnesses that might apply to only a small segment of Florida physicians.



It is fitting that this issue of *The Journal* inaugurates a new journalistic style. For just as our theme "The Process of Aging" implies a continuum through life, so too *The Journal* takes another step in its development. Just as aging should be considered in many ways a beginning or a new chapter and not an ending or an epilogue, so too *The Journal* changes with the times and takes on a fresh look. The editors spent many hours over the past year considering changes in *The Journal's* style which have now been realized with this issue.

Although any stage of life can be viewed as another stage of the aging process, we have elected to focus this issue on geriatrics and care of the elderly. As many of the articles point out, there are special considerations and different thought processes involved in treating the elderly and in caring for the process and problems of aging. We hope this special issue will stimulate interest in and an awareness of

the unique problems confronting us during the process of aging.

I wish to thank our editor, Daniel B. Nunn, M.D., and the FMA staff for their help and support. I want to give special thanks to Robert E. Windom, M.D., FMA President-elect, for his help in obtaining the article "The Senior Friendship Center Health Service of Sarasota". While President of the Sarasota County Medical Society, Dr. Windom was involved in the establishment of the center and remains involved today. His interest in this issue does not stop there, however, as he was recently appointed to the National Advisory Council on Aging.

We hope this issue will be of interest to all members and helpful to you in your practice.

Physiology of aging

Ian MacPhail, M.D.

Aging is a biological phenomenon the causes of which, although largely unknown at present, are unavoidable and constantly present. Closely intertwined with the physiological causes are pathological ones, and it is usually quite difficult or impossible to separate one from the other. The hereditary factors which determine the life span of the species and the longevity of most individuals within the species seem to be in overall control.

It is widely believed that the physiological causes are the basic primary causes of aging and in general they are irreversible in nature. The pathological processes which are superimposed upon the physiological ones, affect both the rate at which the physiological processes proceed, and the processes themselves. They are therefore regarded as secondary causes of aging and are acquired under the influence of heredity or sometimes seemingly by accident. They are present in the majority of cases but certainly not all. When present, they accelerate and aggravate the process of aging in addition to contributing additional debilitating factors to the organism. Environmental factors which can modify heredity must also be considered.

Cell replications appear to be numbered •

Numerous theories have been advanced as to the causes of aging. None can be considered as advancing the cause of aging, but a number of them are under active study. Research shows us that the length of life is fixed. There has been no detectable change over the past 100 years in the number of people who live longer than 100 years of age. Hayflick suggests that there is a finite number of cell doublings in the life span of a species. In other words, the number of times that a cell can reproduce itself is limited. Embryonic fibroblasts in tissue culture seem to have a limit of approximately 70 replications. Even if this process is

halted, and the cells held in deep freeze and then thawed and permitted to begin again, the number of replications appears to be constant at approximately 70. The more times that a cell reproduces itself, the less precise is the replication. Thus, the 70th replication may be slightly, but significantly, different from its embryonic precursor. One theory of aging maintains that these cells are sufficiently altered that a healthy immunological system recognizes them as not "self" and thus attacks them. A variation of this is that the cells are not sufficiently changed to produce such a response, but that the immunological system is itself altered and attacks those cells which are actually within the realm of "normal".

Muscle and nerve fibers belong to a group of cells which Cowdry classifies as postmitotic; their ability to divide stops at a certain age of development, usually rather early in life. When such cells are then damaged by the passing of years, they cannot be replaced by new ones. However connective tissue, consisting largely of "intermitotic" cells which continue to duplicate themselves throughout life, infiltrate into the space formally occupied by nerve and muscle fibers. Carrying this idea a step further it is easy to conceive how certain enzymatic levels or other biochemical components become altered over a life span.

Products which accumulate in the aging individual include collagen, chromosubstance and lipofuscin (aging pigments). With increasing age a progressive cross linkage of macro molecules such as collagen fibers takes place. This spontaneous development would appear to be modified by external influences.

At any rate, there is a gradual loss of cells with a decreased number of mitotic cells and a decreased replacement of mitotic cells with increasing errors in preciseness of replication. There is increased cross linkage of collagen, reduced elasticity of tissue, and increased thickness of basement membrane.

The Author

IAN MACPHAIL, M.D.

Dr. MacPhail is an Associate Professor in the Department of Family Medicine, University of South Florida College of Medicine.

Diminished stature • The geriatric population with its disproportionately large number of women is a short group. But other factors besides a preponderance of females contribute to this. Many elderly persons undergo postural changes, in addition to kypho-

sis, among which slight flexion at the knees and at the hips tends to contribute further to diminished stature. Because the long bones do not undergo significant shortening with age, much of the loss in stature must be ascribed to shortening of the spinal column. Shortening of the vertebral column results from the narrowing of the disks plus loss in height of the individual vertebra. Thinning of the disks appears to be the major reason for shrinking stature in the middle years and diminution of height of the vertebra is the major reason for the progressive loss of height thereafter.

Moderate to marked degrees of osteoporotic vertebral narrowing are nearly universal in elderly women, less so in men. The elderly are thus characterized by shortened trunks and comparatively long extremities. These proportions are the reversal of those seen in infancy and early childhood. While there is a two or three percent reduction in span in the older age group, decline in stature exceeds this by a considerable amount, particularly in aging women. Hence, span measurements, even uncorrected, can lead to a rough estimate of height at maturity in the presence of much kyphosis or bowing of the lower extremities.

Loss of bone matrix outpaces growth in most bones. Osteoporosis is an age-related process which appears to be greater for females than males and greater for whites than blacks. Thus bowing of the spine with a loss of height typically appears earlier in white females of light build who are also subject to the common fractures of the femur and wrists.

Sharpening of features • The manner in which subcutaneous fat is distributed over the body undergoes significant changes during our lifetime. There is often a loss of fat in the face along with a simultaneous deposition on the abdomen and hips. In persons in their 80's and 90's fatty deposits tend to disappear from the periphery, although fat deposition is still apparent over the hips and abdomen. Thus the body loses much of its padding and this loss leads to an increasing sharpness of contour and a deepening of previous hollows. This is evident particularly in the hollows of the orbits and axillae, in the supraclavicular and intercostal spaces and elsewhere. Bony landmarks become increasingly prominent and formerly hidden landmarks become easily visible.

Body hair • Multiple factors — racial, genetic and sex linked — determine the maximum amount of hair a person possesses and the subsequent changes with age. In men not subject to sex-linked baldness and in women, the hair loss is not patterned, there is rather a slow thinning out. The hairs become less numerous and may become thinner with the passage of years. Graying tends to precede hair loss and is

also progressive. The net affect of aging on the scalp is a transformation of darker, thicker and more numerous hairs to lighter, thinner and less numerous ones. Aging generally produces a considerable decrease in hair everywhere with the single exception of the face. Here, especially in Caucasians, some men past 40 develop hairiness of the ears and women past 40 often sprout hairs on the lip and chin. Axillary hair is sensitive both to the passage of time and changes in hormonal status. Aging reverses the sequence seen with puberty and there is a gradual loss of axillary hair proceeding from the periphery to the center; the remaining central hairs tend to become thinner, less kinky and grayer. Obvious loss of pubic hair is seen in one/fifth of males and one/third of females. Occasionally one sees a complete loss of pubic hair.

Wrinkling • The muscles of expression give the human face a play of emotion unknown in any other species, but are responsible also for the characteristic wrinkling produced by time. Creasing of the skin, resulting from repeated use of these muscles, tends to occur at right angles to the axis of their contraction. In this way habitual patterns of expression, such as frowning, pursing of the mouth, and smiling produce characteristic wrinkles in some persons earlier in life than in others. Wrinkling also results from the loss of fat and elastic fibers characteristic of aging skin. This leads to a laxness of skin which then drapes itself chiefly in accordance with gravitational pull and produces a ptosis of lids, ears, jowls and submental wrinkling.

Let us now examine our older patient in detail.

Skin • While there are fewer blood vessels these vessels are in fact more fragile, resulting in the well known episodes of unexplained bruising. There is also decreased cell replacement and delayed healing. The epidermis itself is markedly thinned making these previously described bruises much more apparent. There is also a decreased number of sweat glands and reduced melanin production. Seborrheic keratoses and cherry angiomas are much more common, as are "liver spots" which are really senile lentigines. These may appear as pinpoint to slightly larger areas of pigmentation typically in sun-exposed areas of the skin mainly over the face, hands, and forearms. They are harmless and require no treatment. Cherry angiomas are small pinpoint to slightly larger red lesions typically seen on the chest and back and are small collections of capillaries. They are benign and have no malignant potential.

Head and neck • There is loss of elasticity and altered metabolism of the lens and decreased arterial blood supply. Because of the decreased size of the anterior chamber there is of course a marked propensity to glaucoma. With a loss of cochlear sensory cells

and a loss of ganglion cells of the auditory nerve, there is a well recognized loss of hearing in the elderly. This is most noticeable in the high frequency ranges and leads to a loss of selectivity and discrimination. Because of its striking appearance and name, arcus senilis has been given undue import as evidence of aging. It appears as a white line encircling the cornea. As it progresses, it becomes thicker and denser and completely encircles the cornea. It does not interfere with sight nor does it denote fatty degeneration of the heart as was formerly thought. Although it is true that virtually all older persons have some degree of arcus, the association is variable and dominated by individual and racial factors. With decreased function there is decreased ability to accommodate in the eye, resulting in presbyopia. Cataracts, of course, are far more common in this age group and decreasing arterial blood supply often results in macular degeneration.

Chest • There is a decrease in freedom of movement of the chest wall and, with the loss of elastic tissue, decreased compliance of the lung. This results in increased functional residual capacity and volume, and decreased vital capacity, but an unchanged total lung capacity and tidal volume. These changes often result in increased ventilation-perfusion mismatching. There is also strong evidence that suggests that there are altered defense mechanisms in the lung which account for the increased susceptibility to pulmonary infections. The previously described changes result in a decreased PO₂ but an unchanged PH and PCO₂. There is an increased FEV₁ and FVC.

Heart • The normal heart does not change in size with age. There is, however, decreased compliance of the myocardium and vascular structures and increased peripheral resistance. As one ages there is a slowly decreasing cardiac output, but it is of interest that there is an altered distribution of blood flow, with maintenance to cerebral and coronary vessels but a relative decrease to renal and splanchnic vessels. In health there is an unchanged resting heart rate but the heart does not respond well to stress and even in well-conditioned elderly patients there is an impaired response. The increase in peripheral resistance results in the well known increased incidence of *systolic* hypertension. The electrocardiogram shows a left axis shift with some notching and flattening of the P waves. Whether the increased frequency of conducting abnormalities and arrhythmias is physiological or pathological is still open to investigation.

The gastrointestinal system • There is a decreased number and quality of teeth. With changes in facial bones and with poor fitting dentures, mastication is often a problem. The motility of the entire gut

is decreased and there is decreased salivary and gastric acid secretions and decreased gastric emptying rate. The liver often decreases in size and there is a marked decrease in microsomal enzymes. All of these changes are associated with an increased incidence of hiatal hernia and diverticulosis, although the bulk of bowel content over a period of years may be a factor in the production of the diverticula. Changes in absorption from the gut result in decreased absorption of calcium.

The renal system • There is a decrease in the number of functioning nephrons with a decrease in glomerular filtration rate. Also, there is a decreased renal plasma and blood flow. These all result in impaired concentrating and diluting capacity. The bladder demonstrates a decline in capacity and of course a loss of muscle tone. Enlargement of the prostate is so universal as to be practically considered normal.

All these changes result in decreased creatinine clearance despite a normal serum creatinine, delayed elimination of drugs and impaired ability to maintain fluid homeostasis. In men in particular, there is an increased incidence of obstruction and, in both sexes, an increased incidence of incontinence.

The neurological system • In the elderly there is a decreased number of neurons and a decrease in the nerve conduction velocity as well as decreased autonomic responses. The neuro transmitters are also changed with an increase in MAO and serotonin and a decrease in norepinephrine. Clinically one notes an increased incidence of depression, and of Parkinson's and Alzheimer's Diseases. Sleep is changed with frequent arousal. There are diminished tendon reflexes and diminished vibration sense. Occasionally one also finds diminished position sense.

The endocrine system • After the menopause there is an increase in the levels of FHS and LH in women. All the other major hormones are decreased as in the turnover of T₄ to T₃, a decreased secretion and excretion of cortisol, decreased production of renin and aldosterone and estrogen and testosterone. Clinically one notes unchanged T₄ and TSH, a physiological increase in serum glucose and unchanged serum cortisol.

The hematologic system • The hematopoietic marrow is gradually replaced by fatty marrow, although its composition remains unchanged. There is considerable controversy regarding coagulability. The peripheral blood itself is unchanged; however, there is a moderate decrease in serum iron and iron-binding capacity, and iron absorption. For causes that are not completely clear, the sedimentation rate is usually elevated to the region of 40 mm/hr.

Summing up • As we age, we gradually lose the ability to reproduce individual cells. While the changes in the organ systems have been outlined above, the major problems revolve around the body's difficulty in maintaining homeostasis and in responding to stressful incidents.

Remember that the vast majority of senior citizens are taking care of themselves and functioning without disability. This accounts for at least two-thirds of patients over the age of 65. They are, however, desperately in need of *health education* in the broadest sense of that term. The other third usually have multiple diseases, decreased activities of daily living and independence, social and financial problems.

Seniors can learn! They are remarkably teachable unless they have a brain disorder. The image which

we learned in the wards of teaching hospitals is a false one. Not only false in terms of the health of patients over 65, but false in the sense that we learned that so many of them — when they become ill — will very quickly die or end up in nursing homes. If we are to care for older patients, we must be prepared to spend more time with them. They deserve and require a meticulous history and physical examination. Hopefully, this article will help differentiate the physiological changes from the pathological ones.

Recommended Reading

Surgery of the Aged, Chap. 1, pages 1-13, W.B. Sanders Co., 1975.
Clinical Geriatrics, Chap. 29, pages 551-558, J.B. Lippincott Co., 1979

- Dr. MacPhail, Box 13, 12901 N. 30th Street, Tampa 33612.

The well-elderly check-up

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In recent years the public health community has placed increasing emphasis on the importance of periodic health examinations, the hope being that if disease can be detected at an earlier time, it might be more readily cured. There has also been the hope that by assessing health hazards and altering one's unhealthful behavior disease may be prevented altogether.

But the increasing costs of such preventive health checks and the decreasing yields in proven benefits have led to a major controversy. The critics claim such exams waste patients' money, physicians' time and society's limited health care resources, while the supporters believe that disease detection or prevention before one's life is in jeopardy is well worth the time and expense.¹

The two ends of the age spectrum, however, have largely escaped the debate. Most physicians as well as health-care economists, concede that periodic examinations annually or more frequently are appropriate for children under six and adults over sixty; although just what to include in these examinations remains unsettled.

The well-baby check-up has long been an unchallenged tradition, but as more and more well babies are living into old age (the expected average life span of Americans is now over 73), the "well-elderly check-up" has more recently itself come of age. In the later years of life, much as in the earlier years, certain vulnerabilities occur which may lead to serious disability or death, which many times could be averted by early detection and appropriate intervention.

The goal, therefore, of the well-elderly check-up is to *detect and protect* against the major health hazards of late life. The purpose of this discussion is to establish a framework for accomplishing this goal.

We can conveniently consider the health hazards of later life in three categories: (1) the major causes of death; (2) the major causes of disability; and (3) the physical and psychological consequences of aging. The major causes of death and disability are depicted in Tables I and II.² One category, cardiovascular diseases, heads both lists. The physical and psychological consequences of aging are not as clearly defined, but just "growing old" with the phenomenon of retirement, loss of friends, isolation, financial limitations and the gradual physical and mental decline of aging

are true health hazards that must be recognized and dealt with.

Knowing the major health hazards, however, is only a beginning. The critical question is which ones have a potential for *detection and protection*? To be an appropriate target for the well-elderly check-up, a condition should meet three criteria: (1) the condition must have definable risk factors which if modified may prevent overt disease from developing; or (2) the condition must have an asymptomatic period during which detection and intervention can be expected to significantly reduce morbidity and/or mortality, and (3) there must be available practical methods of detection of risk factors or early indicators of disease.

Table 1. — Leading causes of death for persons 65 and over, both sexes, 1970²

Disease	% of Total
Cardiovascular (CAD, HTN, CVA, PVD)	65
Cancers	15
Pulmonary disease (COPD, FW, PNEUMO.)	5
Diabetes	5 2.5
Accidents	5 2.5
Liver/Kidney	< 1.5
All others	< 10.0

Table 2. — Leading causes of disability for persons 65 and over, both sexes, 1974²

Disease	% of Total
Cardiovascular (CAD, CVA)	28.4
Musculoskeletal (arthritis, fract.)	26.8
Sensory impairment (blindness, deafness)	12.1
Diabetes	6.8
Pulmonary	4.4
Mental	3.4
All others	< 20.0

Detection • Although the basic premise for the well-elderly check-up is that the subjects being examined are "healthy", in fact, it is likely that over 80%

of those seen will have one or more significant medical problems.³ Thus, this examination is more than a "simple screen", it must be comprehensive enough to ferret out not only risks of later or latent disease but also symptoms and signs of present disease states. Like the well-baby check-up, most of these examinations will take place in the private physician's office, although the format is adaptable to clinic or larger screening programs.

Thus, the examination is based on the standard history-physical-laboratory assessment, with several differences in emphasis. Rather than the focus being on a set of symptoms in order to arrive at a single diagnosis, a more global approach is needed to focus on the alterable major killing and disabling disorders. These different points of emphasis will become apparent as each segment of the examination is reviewed.

History • Ordinarily, in the absence of a "present illness", the history will have four main segments:

The *family* history should document relevant illnesses of siblings, as well as dates and ages of death. At this age the status of the patient's children — not only regarding health, but also the family relationships, geographical proximity and financial dependency are important.

The *personal past* medical, surgical and psychiatric history is most relevant as to those problems which may have recurrences. Particularly important are radiation exposure, prior cardiovascular events, metabolic derangements, previous surgery or malignant disease.

The *personal life-style* history is relevant for key risk factors for disease, especially the self-abusive behaviors—improper eating, under exercising, smoking, heavy drinking. Also, often critical is the kind of relationship with one's spouse. Many elderly patients have clustering of life-style changes—retirement, loss of spouse, relocation, financial loss. Recent studies have shown that such clustering of major life events may increase one's vulnerability to disease.⁴ Information garnered from this portion of the history provides key data upon which to counsel the patient in an effort to decrease risk for later disease.

The *systemic review* takes on major importance in the well-elderly check. A careful inquiry about each system should be made with the same care one seeks out symptoms for a "present illness", for it's here where one finds the early clues to potentially serious disease.

One should begin with a general assessment regarding any significant change in stamina, well-being and body weight. Often a vague complaint of "I'm tired all the time", "I can't do the things I used to do", or "I just don't feel good", may signal that something is wrong and by probing each system systematically you may be able to pinpoint the problem. Key symptoms and their meaning are depicted in Table III.

Physical • Many portions of the routine physical examination which are often short-cutted in younger persons need to be included in the well-elderly check-up.

Let's begin with the basic measurements, often relegated to an aide and not given serious attention: height, weight, temperature, pulse, respirations, blood pressure.

A great deal of attention is paid to over-weight, although little is usually accomplished in trying to change it; weight loss, however may be of great significance. On the other hand, minimal attention is paid to height and a great deal can be done to preserve it.⁵ All post-menopausal females should be asked how tall they were at age twenty-one before they step on the scale to be measured. If they have "shrunk" more than two inches, you can bet they have significant osteopenic vertebral disease and are headed for trouble if left unattended.

Although blood pressure is always recorded, all-too often in the "elderly", a systolic elevation is considered either normal or benign, when in fact it is neither⁶ and may be the major risk factor for stroke and/or myocardial infarction in late life.

Table 3. — Points of emphasis on the systemic review in the well-elderly check-up.

System	Symptom	Potential Problem
Head/Neck	Headache Dizziness Visual SX.	HTN., Temp. Arteritis TIA., Vasc. Menieres Cataract, Glaucoma, Retinal Detach., TIA.
Card./Resp.	Chest Pain Dyspnea Cough	Angina COPD., CHF. Bronchitis, CA.
Gast./Intest.	Abdominal Pain Anorexia Bowel Change Rectal Bleeding	Ulcer, CA. Cirrhosis, CA. Dietary, CA. Diverticulae, CA.
Genital/Sexual	Dyspareunia Stress Incont. Impotence Nocturia	Estrogen Def. Cystocele Psych., Vasc. Diabetes, BPH.
Musculoskel./ P.V.	Ext. Pain Joint Stiff	Polymyalgia, Claudi- cation, Neuritis Arthritis
Neuro./Psych.	Mental Change Mood Change	Dementia Depression

Before proceeding with examination of individual systems, it is important to make a general appraisal of the patient's overall physical status — observe the patient walking, getting out of a chair and have him perform a few simple exercises.

An often overlooked organ system is the skin. In this age group it may not only reveal signs of primary cutaneous disease (especially skin cancers) but it may also reflect signs of serious internal disease (the palor

of anemia, icterus, acanthosis nigricans, diffuse keratosis signaling internal malignancy).⁷ Specific aspects of the physical examination as part of the well-elderly check-up which bear emphasis are depicted in Table IV.

Table 4. — Points of emphasis on the physical examination of the well-elderly check-up.

Site	Sign	Potential Problem
Head/Neck		
Eyes:	Lensopacities	Cataracts
	Excess Floaters	Retinal Detach.
	A:V Ratio	HTN.
Ears:	Tuning Fork	Hypacusia
Thyroid:	Goiter	Hypo/Hyper Thyroid
	Nodule	CA.
Carotids:	Pulse, Bruit	Atherosclerosis
Chest		
Breasts:	Lumps	Dysplasia, CA.
Lungs:	Expir.	COPD, Asthma
Heart:	Abn. Rhythm, Murmur, S ₃	ASHD, HT, HD.
Abdomen		
	Hepatomegaly	Cirrhosis, CA.
	Splenomegaly	Myeloprolif. Syno.
	Masses	CA. Aneurysm
	Wall Defects	Herniae
Genital/(F)	Prostate	BPH, CA.
Rectal (M)	Pelvic	Estrogen Def., CA.
Musculoskel./P.V.	Joint R.O.M.	Arthritis
	Periph. Pulses	Atherosclerosis
Neuro./Psych.	Neuro. Deficits	Neuropathies
	Mental Deficits	Dementias, Depression

Laboratory • The laboratory serves two purposes as part of the well-elderly check-up. First, it offers the potential of discovering problems that are not detectable on the clinical evaluation. Second, it provides confirmation of clues gathered during the history and physical examination.

Table V lists those tests which have particular relevance to the well-elderly check-up.

One of the most frequently overlooked tests, yet available on every automated complete blood count, are the red cell indices. In the presence of anemia they may immediately indicate the cause and lead to correct treatment. When the mean corpuscular volume (MCV) is elevated without anemia, it may be a clue to covert alcoholism.⁸

The urinalysis also is often not completely appreciated. The presence of pyuria and the mention of bacteria should raise the suspicion of chronic bacteriuria, a condition which may be associated with reduced survival in the elderly.⁹

In recent years, the Hemocult screen for occult intestinal blood loss, when used properly, has proven effective in the early diagnosis of gastrointestinal malignancy.¹⁰

Selective blood chemistry testing may permit early diagnosis of important treatable diseases before

major complications develop and is especially productive in the elderly.

Other Diagnostic Procedures • Perhaps the greatest controversy about periodic health exams at any age occurs when one begins to consider a variety of other diagnostic procedures. Even being selective, the question arises as to who should get what and how often. Here are some them: audiometry, tonometry, spirometry, proctoscopy, electrocardiography (resting/treadmill), radiography (chest, barium studies, mammography).

If one were to follow the recommendations of the Canadian Task Force on the Periodic Health Examination for the age group under consideration, none of these procedures would be included.¹¹ However, a general consensus of specialists is likely to suggest that at a minimum, a resting ECG and a "P-A and Lateral" chest film be done at least every five years in a person over sixty without significant risk factors, otherwise more often.^{1, 12} Although there is no unanimity of opinion on the other tests, most would relegate them to follow-up studies and not consider them practical for the basic well-elderly package.^{13, 14}

Protection • Detection, of course, is only phase one of the well-elderly check-up. Phase Two, *protection*, is what it's all about. There are four elements to Phase Two: (1) institution of treatment for overt disease; (2) patient directed life-style change; (3) physician directed "preventive interventions", and (4) establishment of a sound patient-physician relationship.

Treatment of Overt Disease • As this discussion is concerned with prevention, I will not dwell on

Table 5. — Critical laboratory tests for the well-elderly check-up

Test	Abnormality	Potential Problem
Automated CBC	▲ WBC ▼ HCT N HCT, ▲ MCV	Chronic Leukemia Anemia Alcoholism
Urinalysis	+ Blood + Protein + Nitrate DIP.	U.T. Bleeding lesion Glomerular Disease Bacteriuria
Stool	+ Hemocult	G.I. Bleeding Lesion
Pap	Atypical Cells	Cervical/Uterine CA.
Chemistry Panel	▲ Glucose ▲ Triglyceride ▲ Cholesterol ▼ Cholesterol ▲ Uric Acid ▲ Bun/Creat. ▲ Liver Enzymes ▲ Calcium ▼ Calcium ▲ Potassium ▼ Sodium	Diabetes Diabetes Risk for CA., D. Nutritional Def. Gout; Renal Dis. Renal Disease Liver/G.B. Disease CA. Hyperparathyroid. Osteomalacia Renal Disease SIADH

the treatment of disease. It is important, however, in this age group to know what is best kept under observation and what requires active intervention. For example, asymptomatic hyperuricemia and modest hypercalcemia (due to a parathyroid adenoma) may not require immediate therapy; whereas two other "hypers", hyperglycemia and hypertension do require therapy.¹⁵ Such judgements are sometimes difficult and many factors must be weighed in the balance between choosing to treat or not to treat.

Life-Style Change • There are a number of unhealthy life-styles which should, if possible, be modified no matter what the age. The four most important are: (1) improper nutrition; (2) insufficient exercise; (3) smoking; and (4) excessive alcohol consumption.

Improper nutrition in the elderly depends on many factors: economic, family size, mental status, and other variables. Often the problem is not "over nutrition" and obesity, but undernutrition. A careful dietary history should be obtained in order to assess potential deficiencies. A diet emphasizing complex carbohydrates and fiber—and perhaps supplemented with iron, calcium and a multivitamin preparation to achieve and maintain a reasonable body weight is appropriate for most elderly persons.² Basically such a diet means more fresh vegetables, fruits and whole grains and less meat, oils, dairy products and sweets.

There is currently good evidence to indicate that maintaining a reasonable level of physical activity delays the aging of the musculo-skeletal and cardio-pulmonary systems.¹⁶ A brisk daily walk or swim is an appropriate prescription for most elderly persons.

Although a life-long smoker even if willing to stop at age 65 is not likely to benefit to nearly the extent that a younger individual would, the continuance of smoking may predispose one to respiratory and vascular consequences, especially if one already has some underlying pulmonary or cardiovascular disease. It is thus wise to advise against smoking.

The peak of alcohol catastrophies is in the earlier years, but excessive drinking behavior continues to take its toll in the elderly through cirrhosis, mental deterioration and accidents—and, of course, its global effects on one's family and social relationships.

If one can effectively alter any of these self-abusive behaviors, a significant preventive intervention will have been accomplished.

Prophylactic Therapeutic Interventions • Infectious Disease: Perhaps one of the clearest active interventions for preventive medicine is vaccination for infectious disease. Although pediatricians diligently carry this out in their patients, geriatricians rarely come up to their standard. There are three major vaccinations indicated for the elderly: (1) influenza, annually; (2) pneumococcus, every five years; and (3) tetanus toxoid every ten years.

Observations during influenza epidemics over many years indicate that influenza-related deaths oc-

cur primarily in chronically ill children and adults and in healthy persons over age 65.¹⁷ Influenza vaccine is about 70 percent effective in preventing infection; adverse effects are rare and minor.¹⁸

The pneumococcus remains a major cause of pneumonia. In recent studies of patients older than 65, it was the responsible agent in nearly 45 percent of pneumonia acquired in the community. Case fatality rates are highest in the elderly — 41 percent over 50 years and 61 percent in patients over 70. More than 80 percent of serious pneumococcal infection is caused by fourteen serotypes, twelve of which are incorporated in the available polyvalent, polysaccharide vaccine which has been shown to be safe, antigenic and effective.¹⁹

Tetanus toxoid has a proven reliability for a host to mount an amnestic response years after a primary series, still, booster immunization is advisable every ten years. Many elderly persons have let their immunizations lapse two to three times that interval.²⁰

Cardiovascular Disease • Since atherosclerosis manifesting itself as cardiac, cerebral or peripheral vascular disease is by far the major cause of death in late life, any intervention which might slow the process of atherogenesis would seem worthwhile.² It has been estimated that if this disease could be halted, the potential extension of longevity would be in excess of ten years, far greater than any extension by efforts directed at all other causes of death.²¹ But what are the real expectations? For risk factor reduction, the outlook is bleak. Once a person has reached 60, the key alterable risk factors seem to have much less significance.²¹ For example, there is no evidence that lowering dietary cholesterol, reducing body weight or stopping smoking has any salutary effect on atherosclerosis over 60. There is meager evidence that blocking platelet aggregation, controlling diabetes and raising high density lipoproteins is beneficial. Thus, of the major risk factors for cardiovascular disease, only the control of hypertension (systolic) has been conclusively shown to be efficacious in late life.²²

A history suggestive of angina, however, might lead to further diagnostic studies which, with appropriate treatment, may prevent a major infarction. Recently beta blockers have emerged as agents that have the potential for curtailing second myocardial infarctions.²³ Why not the first infarction as well?

The finding on physical examination of significant decreases in carotid artery pulses or asymptomatic bruits may lead to effective therapy that could prevent a major stroke.²⁴ Similarly, discovering a silent aortic aneurysm or femoral artery deficits or bruits could also lead to effective preventive intervention.

Cancer • What can we expect regarding the prevention of cancer by periodic surveillance of the elderly?

Approximately two-thirds of the cancer deaths in the elderly female are due to Breast, Colon and

Uterus, while two-thirds of the cancer deaths in the elderly male are due to Lung, Colon and Prostate.²⁵

At present, there is little in the way of reasonable (conservative) methods of primary prevention for these cancers when efforts are first undertaken after the age of 60 years. Perhaps dietary alterations which significantly increase fiber content can curtail colon cancer²⁶, but whether making this alteration late in life is effective has yet to be proven. (It may relieve serious constipation and save some patients from complications of diverticular disease).

What we can expect, however, is a sensitivity to the early signs of these cancers so that the patient may be afforded the potential for a cure through early detection—especially in the case of breast, uterus and prostate. The recent enthusiasm regarding early detection of lung cancer by sputum cytology has been dampened by evidence that the chest x-ray may yet be the most sensitive diagnostic screen for *early* lung cancer.²⁷

Metabolic Disease • Except for complications of diabetes (myocardial infarction, hyper osmolar coma), most endocrine/metabolic disorders in the elderly are uncommon as lethal diseases; yet there is a significant increase in major endocrine gland dysfunction to make this group important. Hypothyroidism and hyperthyroidism are commonly "masked" and in some instances, only by laboratory survey can they be detected. Thyroid failure and thyroid nodules (carcinoma) are frequent enough in the elderly to make consideration of prophylaxis with physiologic doses of thyroid a reasonable option. Hyperparathyroidism is primarily a disease of the elderly²⁸ and although the diagnosis should not lead to surgery in all cases, it may aggravate the other common metabolic bone diseases seen in this age group and, if high levels of calcium are found, surgery may be necessary.

Metabolic bone disease is perhaps one of the most under diagnosed, potentially lethal, and frequently disabling diseases of older Americans, especially females. Osteomalacia (due to lack of calcium) and osteoporosis (due to lack of bone matrix and primarily the result of estrogen deficiency) are easily diagnosed and effectively halted by a combination of dietary and hormonal therapy which affords us a major prophylactic intervention.²⁹ Another silent malady of the elderly is hyponatremia and hyperkalemia occurring as a consequence of renal functional impairment, easily corrected once detected.³⁰

Aging • What about the process of aging per se? Is there anything that can be done to curtail the progressive process of cellular aging as the clock winds down? As there is presently no one uniformly accepted theory as to the cause of aging, it would seem that little could be offered in the way of an "antiaging agent."³¹ Nonetheless, there are some things that

might be considered. First, physical aging of the musculoskeletal and cardiorespiratory systems can probably be delayed by a lifelong program of regular "physical activity".³² Second, although the data is meager, "mental exercise" may also be important to curtail senescence.³³ There is also some hope from recent studies that certain agents which have not proven effective in reversing dementia (ergot alkaloids and nontropic agents) might be more effective in preventing it.²³ And finally, as one of the prominent theories as to the pathogenesis of aging revolves around excessive cellular oxidation by free radicals³⁰, certain dietary alterations as well as antioxidants (vitamin E is a potent antioxidant) may hold promise in slowing cellular aging.³⁵

Both the major diseases which lead to death and disability in the elderly as well as the aging process itself may be significantly altered by close prophylactic surveillance and intervention yet, the well-elderly check-up goes beyond the discovery of disease. The value of the relationship established between the older patient, the family and the physician is an important bond for future medical care. A doctor who knows the patient well can better prescribe treatment when illness does occur. The patient, on the other hand, having established a trusting relationship is likely to be more comfortable in seeking help and more reliable in complying with treatment when symptoms appear.

Conclusions • Primary prevention, perhaps better termed "health promotion", and secondary prevention of overt disease and early intervention are worthwhile and accomplishable goals in the elderly.³⁶ It is obvious from this review that we still face many challenges. Virtually any preventive technique for use on asymptomatic adults is based on incomplete data, and even those things we as physicians would like to change all too often are unacceptable to the well-elderly. Nonetheless, physicians must act today based on the best available data and on their own judgments as to what they consider to be appropriate to enhance the quality of life for their elderly clients.

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The senior friendship center health service

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After spending more than 43 years in the private practice of medicine in Boston and suffering from several bouts of pneumonia, as well as probably Legionnaire's Disease, I was advised by my thoracic physician to move to a warmer climate. On the recommendation of two friends I came to Sarasota on an extended vacation and found it a most satisfactory place in which to live.

I met two former psychiatric social workers and they introduced me to Brother William Geenen, a Catholic Brother of Holy Cross from Notre Dame who had established a number of senior friendship centers in the area. I was informed that Florida had recently passed a very forward-looking law which states that a limited license may be issued to a retired physician who had held a license and practiced in another state for at least ten years and whose license was in good standing at the time of his retirement. However, the recipient may practice only in the employ of a non-profit agency which is providing care in a medically underserved area. Brother Geenen and I felt that such a need existed and set out to prove it.

The Council on Aging • I worked with the Council on Aging which had made a six-month survey and they found that there were 7,000 older people in the county who had not seen a doctor in a year, with another 6,000 who were able to afford only one visit a year. With these figures I was able to convince the Sarasota County Medical Society that a health facility such as we planned was essential.

I made application for my limited license and met the requirements for this type of license. I worked under the supervision of the Sarasota County Health Department, which was supervised by Dr. Henry Morton. The Senior Friendship Center had just purchased a large building which was renovated and a number of rooms were allotted to the health facility, which included a waiting room, a consultation office

and an examining room. I was immediately able to recruit another retired physician and, then, another.

At the beginning we saw patients two mornings a week, but our patient load increased quite rapidly and we outgrew our quarters. With the aid of a federal grant we were able to make a down-payment on another building and through the generosity of a Sarasota resident, Mr. Harry Sudakoff, we were able to furnish and equip it completely. We now have six combination office and examining rooms, staffed by 26 physicians, 25 volunteer nurses (a most caring and dedicated group), as well as volunteer secretaries. All of the staff are retired and donate their time. The hours have been extended to four mornings and afternoons a week, with two doctors on duty each time, and we hope to make this five days a week soon.

Local medical community • We realized from the start that we could not function without a good relationship with the local medical community. We met with the Sarasota County Medical Society, which extended its blessing to our project. Our communication with each other has continued to be excellent and we meet regularly with the President of the Sarasota County Medical Society, the President of the Florida Academy of Family Physicians, the Chairman of the Sarasota Memorial Hospital, the Director of the Sarasota County Health Department, and frequently, with past presidents of the Medical Society.

We constantly refer patients to private physicians. Many patients are new and are introduced into the medical system. Also, patients with emergencies and/or near emergencies are referred to a qualified doctor. The County Medical Society's secretary notified us of all new doctors who have come into the area every three months, so that we can easily make appointments for patients in need. Since we are all retirees and are not available to make house calls or to have hospital affiliations, our practice is limited to the prevention and to the treatment of those who really need monitoring or limited treatment. All our patients are required to have a "back-up" doctor and this is made clear to them.

Older people need to have available a doctor who will listen to their complaints and symptoms, to whom they can "pour out" their fears and bewilder-

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ment. For this reason, one of our rules is that each new patient must be allotted at least a 40-minute appointment the first visit, and as often as necessary after that. We have found that many are not suffering from a serious, debilitating, organic disease, but from depression caused by the loss of a spouse, a friend, or by the inability to make meaningful relationships with others.

Thorough physical examinations • We make certain that organic disease does not exist by completing a thorough physical examination and, by obtaining laboratory tests, when necessary. Sometimes the patient is introduced into the activities of the Senior Friendship Centers. After becoming a part of a group, many physical symptoms disappear. True senility is rare and what may appear to be senility is discovered to be loneliness, with a concomitant withdrawal from life, and depression. Then, the Friendship Centers become a therapeutic modality, involving people both socially and intellectually. Chess, checkers, courses in languages, creative writing, photography, and exercise are among the activities offered. Involvement with others is vital. I have seen many who have been involved through this, been helped to help themselves, and, then, reach out to help others.

The media commended us for our work. This includes national television via Hugh Downs's "Over Easy" program, Dr. Art Ulene's syndicated program, and Charles Kuralt's "Sunday Morning" program on CBS. Last spring the Health Service received a plaque

from the Governor's wife as the volunteer organization having the greatest impact on the State of Florida. Our facility may become a model for replication in the State, and has received national attention. Our center is the only one of its kind in the country.

Monthly staff meetings • The medical staff meets once a month to resolve any problems that have arisen. The nurses also meet monthly. We present health lectures on a monthly basis, given by one of the physicians in the area, on a topic of interest to the older person. These are open to the public. We try to teach our patients about their illnesses, their medications, and their nutrition. We have just received permission from the American Medical Association to use its booklet, "The Wonderful Human Machine", as the basis for a local television mini-series, explaining how the systems of the body function. The existence of *any* medical service can be justified only by its contribution to the system of care provided for the people of the area. With an increase in the proportion and number of elderly in Sarasota County and Florida, there is a need to deal with the special problems of this age group. In this country there is still the question of separating out the elderly for special medical attention (i.e. the specialty of geriatrics) or of including them in a spectrum of coordinated health care services. At the Senior Friendship Health Service we are trying to do the latter.

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Drug use in the elderly

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Physicians know that the dose of a drug for children is less than that for an adult, but it is not as well appreciated that much the same principle holds true for the aged. The handling of drugs (pharmacokinetics) and the effect of drugs (pharmacodynamics) change as people grow older. Standard drug dosages are generally worked out in young adults and changes necessary in the elderly are usually not included in standard dosing information.

The elderly have two to three times as many drug reactions as do younger persons.^{1, 2} This is secondary to the greater use of drugs and to altered drug handling in the elderly.

Pharmacokinetics • The major factors affecting how drugs are handled are listed in Table 1. Aging primarily affects distribution and renal excretion. With aging, important changes in body composition occur (Table 2). Diminished plasma volume, total body water, and extracellular fluid indicate a decrease in lean body mass and a smaller muscle mass to act as a drug reservoir.³ Accordingly, drugs distributed mainly in body water will result in higher blood levels if given in doses used in younger patients. For example, ethanol is evenly distributed throughout body water. At doses calculated on the basis of body surface area, elderly persons achieve higher blood concentrations even though the rate of ethanol metabolism is not affected by age.⁴ This results from the smaller total volume of distribution of ethanol due to decreased body mass in the elderly.

The most important and best understood factor affecting drug handling in the elderly is the progressive decline in renal function that occurs with age. Glomerular filtration rate falls by about 35 percent between ages 20 and 80.⁵ Serum creatinine and BUN levels remain normal and do not reflect this functional change. Creatinine values remain normal because muscle, the source of creatinine, concomi-

tantly decreases with aging. BUN values do not rise because of decreased protein intake, the major source of urea. Since renal reserves are diminished, abrupt deterioration in renal function can occur from circulatory changes (heart failure, dehydration) or from intrinsic renal disease (infection, obstructive uropathy).

Table 1. — Changes in pharmacokinetics with aging

	Change
Absorption	0
Distribution	↑ or ↓
Protein binding	?
Hepatic metabolism	? ↓
Renal excretion	↓

Table 2. — Changes in body composition with aging

Component	Age Range	% Change
Ratio: Body fat to body weight	20 70	↑ 35
Plasma volume	20 80	↓ 8
Total body water	20 → 80	↓ 17
Extracellular fluid	20 → 65	↓ 40

Decreased renal function must be presumed in all elderly patients and allowances must be made for dosage reduction of drugs excreted by the kidney in active form (Table 3). With some drugs (e.g., digoxin, gentamicin, lithium carbonate), plasma levels may help in determining proper dosage. The only way to accurately measure renal function in the elderly is by determining the creatinine clearance. At times this is not possible because of incontinence or forgetfulness. In such instances a good estimate of creatinine clearance can be made from the patient's age, weight, and serum creatinine level using the following formula:⁶

$$\text{estimated creatinine clearance} = \frac{(140 - \text{age}) \times \text{weight (kg)}}{72 \times \text{serum creatinine level}}$$

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Table 3. — Some drugs excreted in active form by the kidneys

digoxin (Lanoxin)
procainamide (Pronestyl)
aminoglycoside antibiotics
streptomycin
kanamycin (Kantrex)
gentamicin (Garamycin)
tobramycin (Nebcin)
ethambutol (Myambutol)
nitrofurantoin (Furadantin, Macrochantin)
methenamine salts (Hiprex, Mandelamine, Urised, others)
lithium carbonate
sulfamethoxazole (Gantrisin, Bactrim/Septa)
phenobarbital
chlorpropamide (Diabinese)
acetohexamide (Dymelor)
allupurinol (Zyloprim)

Drug Induced Illness • About 5 to 15 percent of elderly patients with dementia have a reversible cause, and the commonest reversible cause is a drug reaction. Complaints of forgetfulness, confusion, weakness, loss of appetite, tremor or emotional distress (anxiety or depression) may be accepted by both patient and physician as signs of aging and may not be related to drugs taken.

Use of multiple drugs that cause sedation or central nervous system depression is common in the elderly. Some frequent drugs used in the elderly that cause sedation are listed in Table 4. Psychoactive drugs produce some degree of sedation and multiple use of such drugs has an additive CNS depressant effect. All anticonvulsants and antihistamines have some sedating properties. In fact, the active component in over-the-counter sleeping pills is an antihistamine. Benadryl has such marked soporific effects that it has been used as a mild hypnotic.

Corticosteroids usually produce euphoria but can cause depression, especially in persons with a previous history of depression. Estrogens, too, can cause depression, best appreciated as an effect of birth control pills.

The antihypertensive agents hydralazine (Apre-soline), and notably methyldopa (Aldomet), can cause sedation. Reserpine is a common component of combination preparations for hypertension. Its propensity to cause depression is well recognized. Digoxin (Lanoxin), procainamide (Pronestyl), and beta-blocking drugs can produce fatigue, lethargy, and depression.

The ability of narcotic analgesics to produce

sedation is one of their useful clinical effects. But codeine and propoxyphene (Darvon) in *standard* doses can cause marked sedation and confusion in aged persons.

Drowsiness or depression can be produced by some antituberculous drugs and antineoplastic agents.

A variety of drugs usually not thought of as producing CNS effects can cause sedation, depression, or confusion. Among those more commonly used in the elderly are amantadine (Symmetrel), levodopa (Laradopa), cimetidine (Tagamet), and indomethacin (Indocin).

Table 4. — Drugs able to cause sedation

sedatives-hypnotics
benzodiazepines (e.g., Valium, Librium)
tricyclic antidepressants (e.g., Elavil)
phenothiazines (e.g., Thorazine)
haloperidol (Haldol)
thiothixene (Navane)

anticonvulsants (e.g., Dilantin)
antihistamines (e.g., Benadryl)

hormones:
corticosteroids
estrogens

cardiovascular drugs:
hydralazine (Apre-soline)
methyldopa (Aldomet)
reserpine
digoxin (Lanoxin)
procainamide (Pronestyl)
propranolol (Inderal), and other beta-blockers

analgesics:
narcotics (e.g., Demerol, Talwin)
codeine
propoxyphene (Darvon)

antituberculous drugs:
cycloserine (Seromycin)
ethionamide (Trecator-SC)
isoniazid (INH)

antineoplastic drugs:
vinblastine (Velban)
vincristine (Oncovin)

Other drugs:
amantadine (Symmetrel)
acetazolamide (Diamox)
chloramphenicol (Chloromycetin)
cimetidine (Tagamet)
Lomotil
indomethacin (Indocin)
levodopa (Laradopa)
methysergide (Sansert)

Digoxin • The drug that best exemplifies the potential for adverse reactions due to age-related pharmacokinetic changes is digoxin. The major contributing factors are decreased renal function and, to a lesser extent, smaller body mass.⁷ Digoxin is almost completely absorbed from the gastrointestinal tract and

excreted in active form in the urine. The half-life of digoxin increases from 38 hours in the young to 68 hours in the elderly. Volume of distribution is also decreased because of smaller body mass.

As a result, a given dose of digoxin in an elderly person produces a higher blood level that remains elevated longer. Therefore, the proper digoxin dose for elderly persons is smaller than that for younger persons.

Digitalis intoxication • Digitalis intoxication produces cardiac and noncardiac symptoms. An accidental outbreak of digitalis intoxication due to an error in formulation of digoxin tablets showed the frequency of noncardiac symptoms (Table 5).⁸ Fatigue, weakness, and psychic disturbances, among the most common symptoms noted, could easily be attributed to aging or "senility." Although anorexia and nausea are well recognized symptoms of digitalis intoxication abdominal pain, which occurred in two-thirds of persons, this is usually not appreciated as a symptom of digitalis toxicity. Visual complaints occurred in almost all persons, often as initial complaints. Hazy vision and difficulty reading would not likely raise the suspicion of digitalis intoxication. It is also important to appreciate the CNS toxicity occurred with plasma digoxin levels in the therapeutic range.

Table 5. — Noncardiac symptoms of digitalis intoxication

Fatigue	95%
Weakness	82%
Psychic Disturbances	65%
bad dreams	
restlessness	
nervousness	
agitation	
listlessness	
drowsiness	
fainting	
delirium	
Anorexia and Nausea	80%
Abdominal Pain	65%
Visual Complaints	95%
hazy vision	
difficulty reading	
altered colors	
photophobia	
glittering lights	
scotomata	

Need for Digoxin • Elderly patients are often started on digoxin for the wrong reasons; one must be sure that the elderly person has congestive heart failure. Fatigue or dyspnea with exertion, rales, and ankle edema — (alone or in combination — are common complaints and findings in old people; but they do

not necessarily indicate heart failure. Too many elderly patients have been treated for heart failure because of the presence of one or more of these findings when, in fact, heart failure was absent. One needs to look for cardiomegaly (best determined on a chest x-ray film), an S3 heart sound, neck vein distension, an enlarged liver, and hepatojugular reflux as corroborative signs of heart failure.

In one study of elderly patients receiving digoxin, the drug was stopped in almost three-quarters of the patients without any detrimental effect.⁹ Another study of elderly patients in sinus rhythm showed that plasma digoxin concentration had predictive value in assessing the safety of discontinuing the drug.¹⁰ When plasma digoxin levels were less than 0.8 ng/ml, digoxin was safely stopped in 33 of 34 patients; while in 7 of 22 patients with plasma digoxin levels between 0.8 and 2.0 ng/ml, either heart failure or atrial fibrillation followed cessation of digoxin therapy. Therefore, if clinical control can be maintained with low plasma digoxin levels the drug is probably not necessary.

Recommendations for digoxin use • The usual maintenance dose of digoxin in elderly persons is about half that recommended for younger patients. Therefore, 0.125 mg per day should be used in the elderly. Unless there is clinical urgency there is no need to start with a digitalizing loading dose. Beginning the treatment of congestive heart failure with 0.125 mg of digoxin daily will lead to fully therapeutic plasma levels within eleven days.

Before starting treatment with digoxin a serum potassium level and a creatinine clearance need to be measured. The latter can be estimated as already described. Plasma digoxin levels may be useful in gauging treatment but one must rely on clinical response and clinical judgment in assessing response to the drug.

Antihypertensive drugs • Hypotension from antihypertensive drugs is common in the elderly because peripheral venous tone decreases with age as do baroreceptor responses. The dose of antihypertensive drugs must be carefully titrated to avoid orthostasis and syncope which can lead to ischemia of vital organs and resultant myocardial infarction or stroke. It must also be remembered that postural hypotension can be induced by drugs other than antihypertensives (Table 6).

Table 6. — Drugs causing postural hypotension

Antihypertensive Agents
Nitrates (especially nitroglycerin ointment)
Procainamide (Pronestyl)
Tricyclic antidepressants (e.g., Elavil)
Phenothiazines (e.g., Thorazine)

Barbiturates • Barbiturates should not be used in the elderly. Paradoxical reactions, ranging from restlessness to excitation, can occur in aged persons. One cannot tell from the names of some compounds (e.g., Bronkotabs, Quadrial, Robinul-PH) that phenobarbital is a constituent. Care must be taken in prescribing.

Elderly patients taking barbiturates regularly (e.g., as an anticonvulsant) who have no problems with the drug need not have it discontinued.

Benzodiazepines • The incidence of drug reactions to a given dose of a benzodiazepine increases with the age of the patient. Adverse reactions to 30 mg or more of flurazepam (Dalmane) increase from 5 percent in patients under age 40 to 40 percent in patients over age 70.¹¹ Accordingly, the hypnotic dose of flurazepam in the elderly is 15 mg rather than the 30 mg recommended for younger patients.

Many benzodiazepines are metabolized to active compounds with long half-lives. For example, diazepam (Valium) has a half-life of 51 hours while its active metabolite has a half-life of 151 hours. Therefore, the dose of benzodiazepines with active metabolites (diazepam/Valium, chloriazepoxide/Librium, clorazepate/Azene, Tranxene) should be a half or a third of that in young patients. Chronic use should be avoided. Theoretically, benzodiazepines without active metabolites (oxazepam/Serax, lorazepam/Ativan) are better choices for elderly patients.¹²

Tricyclic antidepressants • The same dose of imipramine (Tofranil) and amitriptyline (Elavil) produce higher blood levels in older patients.¹³ Accordingly, it is safer to start treatment with small doses in older patients.

The common side effects from tricyclic antidepressants are especially troublesome in elderly patients. Sedation is most common with amitriptyline (Elavil). Orthostatic hypotension and cardiac arrhythmias are a particular danger in patients with heart disease. Amitriptyline has the greatest propensity to produce arrhythmias while desipramine (Norpramin, Pertofrane), doxepin (Sinequan), and nortriptyline (Aventyl) are less likely to do so. Tricyclic antidepressant drugs have anticholinergic effects and can produce dry mouth, worsen glaucoma, or lead to urinary retention.

Major tranquilizers • The major tranquilizers include phenothiazines, thiothixene (Navane), and haloperidol (Haldol). Extrapyramidal side effects from phenothiazines are common in the elderly and can be particularly severe from Navane and Haldol. Conversely, sedation and hypotension are a greater problem with phenothiazines than with Navane or Haldol.

Since the elderly are more prone to adverse effects from these drugs, they must be used with care

and in reduced doses. Starting with half or even a quarter of the usual initial dose used in younger patients is appropriate. The dose can then be titrated upwards slowly depending on clinical response and the appearance of any adverse effects.

Summary • The elderly are prone to drug reactions because of multiple drug use and altered handling of drugs. Adverse effects can be lessened or prevented by using the fewest possible drugs in the smallest effective doses. Drug-induced lethargy, drowsiness, and confusion are a particular danger in the elderly. It must be remembered that these symptoms in an older person may be due to drugs taken.

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What's in your bag, Doctor?

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The doctor's bag is an essential part of a quality primary care practice. This is especially true as the number of homebound elderly individuals increases rapidly. It is long overdue for the emphasis on health care for the disabled elderly to be switched from the office and institution to the home.

The estimates of the number of the impaired elderly needing home care services range from 25 to 40 percent¹ and in black families the figure is 90 percent.² The five percent of those over 65 who are bed-fast or homebound equals the total of those who reside in nursing homes. Obviously, a physician's house call is not needed frequently for such a large group, but it is evident that after relative disuse for decades,³ the doctor's bag is coming back on the scene.^{4 5 6}

The percentage of individuals living into their ninth decade of life is growing more rapidly than the percentage of the population going into their seventh decade. The rate of dependency soars in the former as the cardinal diseases/problems develop: confusion, falls, incontinence, failing special senses, impaired homeostasis, iatrogenic complications, and socioeconomic hassles. It is timely to review the indications and the disadvantages of house calls and the contents of the bag for geriatric practice.

Indications • Housecalls are indicated for the homebound elderly for four general reasons: 1) better medical results for many acute and chronic problems, 2) patient and family satisfaction, 3) lower costs, 4) for consultation as a member of a health care team. Cuthens separated the house calls in family practice into different types such as emergency, acute illness, chronic illness, management and placement, grief, terminal care, and to pronounce death.⁵ The article pointed out the trend from emergency calls in the

past to problems with chronic illness making up 80 percent at present.

The four general reasons mentioned as indications for house calls can be illustrated by giving an example. A 92 year old alert individual who is homebound with the residuals of a stroke starts vomiting from a viral gastroenteritis. Thorazine, 12.5 mg intramuscularly given after the assessment, reversed the trend toward the need for hospitalization. On the same visit, the physician got enough information to advise the visiting nurse and physiotherapist about the rehabilitation program. The four general indications were covered. The confusion and exhaustion from transferring to a hospital were avoided, recovery was relatively rapid, the family life was not seriously disrupted, the cost was a small fraction of a hospital bill, and the health care team was able to coordinate the therapy plans.

The importance of the physician to the families of the homebound elderly is evident in the study by Eggert.⁷ The emotional support ranks high, and no other person can offer such definitive advice on most medical matters. There is a trend to treat even complicated and potentially fatal illnesses at home. The issues of safety and cost of home vs. hospital treatment for acute myocardial infarction, transient ischemic attack, stroke, or other catastrophic event do not require hospitalization. When there is not an absolute indication for hospitalization, the patient, family, and friends may be helpful in making the right decision.

There is an increasing demand for physicians to consult with and supervise other health personnel concerning management and disposition.¹⁰ At the present time, there are over 2,000 agencies in this country providing home health services.¹¹ Home visits are usually essential if the physician is to give the best advice on multi-discipline management or the need for placement in an institution. The home care industry is erupting so rapidly that the physician must be concerned about the appropriate use of public and other third-part funds.

There are other indications for house calls that should be noted. These include a paucity of hospital and long term care beds or facilities. Further, one

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should mention the increased knowledge the physician learns about socio-economic factors. And for the idealist, there is the improved image of the profession in society. These matters affect immediate and future care. The personal satisfaction of helping others in this way is also significant.

Disadvantages • The disadvantages of making house calls come readily and many are universal: overwork, time and expense of travel, limited diagnostic and therapeutic support, night calls, inappropriate demands, fear of unexpected complications, and criminal assault. All are real and common reasons given for not providing the service. Even crime has become an issue in many of our rural communities.

But there are ways to overcome most of these problems. For the overworked doctor, other physicians and extenders are becoming more readily available. Financially, it can be profitable as shown by those practitioners who are doing this type of work exclusively. Time can even be saved if a house call clarifies a problem long unsolved by previous encounters. Training and experience may reduce the need for laboratory and diagnostic support in many instances and reduces the fear of complications. Night call requests in an established practice are justified a great majority of the time. Many faithful patients delay calls about marked pain and other disturbances until morning and "the doctor has had some rest." Certainly in many communities and circumstances, especially for new physicians in practice, there are many inappropriate calls for service. The usual experience is, however, that the irritating calls are rarely from the elderly. Unfortunately, the physician on a house call is a potential victim for a mugging for two reasons: 1) all people are possible victims in some areas, 2) the bag may attract the addict. All types of preventive procedures may be necessary, from police or other protective escorts to secrecy and camouflaging "the bag".

The Bag • Doctor bags are generally leather and come in two colors, black and several shades of brown. Several sizes, shapes and internal arrangements are available. Selection of the right one for the personality of the practitioner, the type of practice, and the arrangement for the contents is most important. The typical black bag is depressing to many people though it is distinctive and denotes the "ole devoted doctor" character. My favorite is the light brown bag that is shaped somewhat like a large brief case. It opens up completely, both sides flush with a flat surface. One side contains mainly diagnostic equipment and supplies and the other therapeutic items. This is particularly suited for those physicians who see executives and other very active individuals. This type of bag seems to suggest more optimism and less disability.

The contents of the bag • What about the contents of the bag? That is not an easy question to answer for those with experience, for it constantly changes. Many useful items may be obtained as samples in small containers from drug representatives. There are particular needs for special visits, new drugs available, and individual preferences for a limited space. There is no specific or standard answer. Are there any unique contents in a geriatric bag? Possibly: The glove, toenail scissors, urinary catheter, and goniometer deserve a special note. Rectal impactions are all too common in bedridden people and cause not only diarrhea but, at times, a personality change. The index finger is a most useful diagnostic tool and it is desirable to have it covered with a glove. The toenails are the most neglected area of the body, in my experience, in both institutional and home care. Long curled, ugly nails are common findings. The physician can have great influence by showing more attention to the comfort and functional needs of feet. Urinary bladder retention is a semi-emergency situation that can be readily diagnosed and relieved when one is prepared. The goniometer is not just for practicing the art of medicine. Measuring the limitations of motion in joints affected by stroke, arthritis, or fracture is an objective way of following the course of therapy. The family can easily be taught to use all items: the glove, toenail scissors, catheter, and goniometer. Records of these and other procedures and observations can be kept for review by the visiting nurse, physician, and other therapist.

A look at the types of medical problems causing homeboundness offers some guidance. They are similar to those noted in nursing homes: arthritis, fractures, stroke, hypertension, cardio-pulmonary insufficiency, diabetes, cancer, dementia, depression, anxiety, infections, urinary incontinence, rectal impactions, impaired special senses, and general debility. Skin defects, peripheral vascular disease, dental, nutritional, and iatrogenic problems should be added to the list. Invariably there are several diseases/problems in each individual. In the elderly, minor disabilities may cause major handicaps, leading to striking acute or long term dependency. In addition to the patient's needs, one is frequently asked to treat a family member or friend.

The bag should be organized by categories such as 1) diagnostic, 2) therapeutic, and 3) supplies. The therapeutic section can be further divided into parenteral, oral, topical, ophthalmic, otic, and rectal. Another method of organizing the therapeutic needs would be classifying the types of drugs needed. The most important of these are analgesics, sedatives, antibiotics, circulatory agents, and a topical anesthetic. Obviously, it does get complicated and one looks for a preparation that serves a multitude of purposes. A good example of a drug for multiple problems is chlorpromazine, which can be helpful to treat nausea,

vomiting, anxiety, psychosis, hypertension, hiccups, alcohol withdrawal, and to potentiate analgesics. Diazepam is another, as a sedative, hypnotic, antispasmodic, and anti-convulsant. Most drugs can be used for two to three specific purposes. Nitroglycerine may relieve angina, as well as the pain from spasm of the esophagus and other smooth muscle.⁵

A selection of drugs and other contents to choose from are listed in Table 1. Most of the items are self explanatory, but a few warrant comment. The Nitrostat as 0.3 mg is preferable to the larger sizes, especially the popular 0.4 mg. sublingual tablet. There are fewer side effects with the smaller tablets. The ethyl chloride for topical anesthesia, the #27 needle, the lidocaine solution, and the triamcinolone are especially useful together for injecting arthritic joints and localized fibrositis, common problems. Again, it is evident that this selection will be incomplete in some manner for each practitioner. It would take about two bags to hold all of the items mentioned. One should become thoroughly familiar with several aspects of the drugs chosen. Questions to be asked and answered include 1) specific individual idiosyncrasies, 2) the recommended dose in the very old patient, 3) the usual side effects and interactions with other drugs and food, 4) the expiration date, and 5) the affect of temperature. The contents should be reviewed at least quarterly to guard against negligence in all of these concerns. If extremes of temperature are experienced, extra care must be taken. Many oral preparations are affected by temperatures outside of 15°C-30°C (60°F-86°F) just as are parenteral drugs. These temperature restrictions may require keeping the bag in the office or home when not in use instead of in the car. These precautions are inconvenient, yes, but most important.

Conclusion • The doctor's bag is making a big comeback. The contents of the bag reflect the experience and capability of the primary care physician to offer the quality and continuity of care that is sorely needed for the elderly in our society. For those interested in a more detailed review of home health care in general, one of the best references is by Brickner.¹² Finally, the author would be pleased to hear from readers who have suggestions that would improve the options listed in the table.

Table 1. — Contents of the bag — for individual selection.

A. DIAGNOSTIC EQUIPMENT

- | | |
|-----------------------|------------------------------|
| 1. Stethoscope | 9. Tuning fork (128) |
| 2. Sphygmomanometer | 10. Safety pin |
| 3. Oto-Ophthalmoscope | 11. Glove/jelly |
| 4. Thermometer | 12. Hemocult slide/developer |
| 5. Tongue blade | 13. Clinistix/Dextrostix |
| 6. Measuring tape | 14. Tubes & slides for blood |
| 7. Goniometer | 15. Culturette/cotton swabs |
| 8. Reflex hammer | |

B. PARENTERAL Rx. — Expiration date? Temperature restrictions?

- | | |
|----------------------------------|-------------------------------------|
| 1. Adrenalin 1:1000 1 ml | 10. Triamcinolone 40 mg/ml. 1 ml |
| 2. Dextrose 25 Gm injectable | 11. Digoxin 0.5 mg — 2 ml |
| 3. Valium 10 ml (5 mg/ml) | 12. Demerol 50 mg — 1 ml |
| 4. Lidocaine 1% — plain 30 ml | 13. Vistaril 50 mg/ml — 10 ml |
| 5. Dexamethasone — 4 mg/ml. 5 ml | 14. Tigan 100 mg — 1 ml |
| 6. Atropine 1 mg | 15. Morphine sulfate — 15 mg — 1 ml |
| 7. Lasix 40 mg — 4 ml | 16. Haldol 5 mg — 1 ml |
| 8. Thorazine 25 mg — 1 ml | 17. Colchicine 1 mg — 2 ml |
| 9. Aminophyllin 250 mg. | |

C. ORAL Rx. (2 each) — Expiration date? Temperature restrictions?

- | | |
|------------------------|-------------------------|
| 1. Nitrostat .3 mg | 9. Tetracycline 250 mg. |
| 2. Tylenol #3 | 10. Ampicillin 500 mg |
| 3. ASA — Codeine #3 | 11. Erythromycin 500 mg |
| 4. Dimetapp Exten tabs | 12. Septra/Bactrim |
| 5. Throat lozenges | 13. Theophyllin 250 mg |
| 6. Dalmane 15 mg. | 14. Zomax 100 mg |
| 7. Imodium 2 mg | 15. Clonidine 0.1 mg |
| 8. Lasix 40 mg | 16. Valium 5 mg |

D. OTHER Rx. — Expiration date? Temperature restrictions?

- | | |
|--------------------------------------|-------------------------|
| 1. Corticaine ointment — 5 Gm | 6. Debrox — 15 ml |
| 2. Neosporin ointment — ophth 3.5 Gm | 7. Ethyl chloride spray |
| 3. Coly-Mycin S — Otic 5 ml | 8. Ducolax suppository |
| 4. Aminophyllin sup — 125 mg | 9. Lidocaine jelly |
| 5. Aromatic ammonia — 1 vial | 10. Steroid cream |

E. SUPPLIES

- | | |
|------------------------------------|-------------------------------|
| 1. Syringes 3 & 10 ml | 7. Scissors (toenail & plain) |
| 2. Needles #27, 23, 20 | 8. 4 x 4's gauge |
| 3. Sterile H ₂ O — 5 ml | 9. #11 Scalpel |
| 4. Airway — small — med. | 10. Small suture set |
| 5. Band-aid (spots, etc.) | 11. Bladder catheter (#14F) |
| 6. Tape 1" (surgical) | 12. Rib belt/3" ACE bandage |

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Complications in the hospitalized elderly patient

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It is well recognized that the hospital and the interventions conducted there can be hazardous for all, and this is particularly so for frail elderly patients. The complications to which the elderly are subject may be either iatrogenic or incidental to the illness which precipitated hospitalization in combination with the altered physiology of the aged. While chronologic age per se may not be a risk factor, the elderly are at increased risk because of their fragile homeostatic mechanisms, multiple medications, multiple problems and loss of physiologic reserve.

Scope of the problem • The actual magnitude of the problem of complications occurring to the elderly when hospitalized is difficult to determine in absolute terms because of differences in criteria for complications used in various studies. Nevertheless, review of the pertinent literature does provide some perspective on the relative risks to the aged encountered in the hospital. Mills, in a 1974 review of charts (primarily from the standpoint of tort liability) from 20,000 hospital admissions documented a risk in those over 65 years old of seven percent as opposed to a risk of four percent in younger patients of the occurrence of what he termed potentially compensable events.¹ Rosin and Boyd at St. Pancras Hospital, London, in 1964 did a prospective study comparing complications in three groups of patients: those admitted to an acute care geriatric unit, long-stay patients in geriatric wards and a control group of admissions to general medical wards (Table 1). The overall incidence of complications was comparatively high because of a rather liberal definition of complications, but most importantly the rate of complications in the over 70 year old group was about twice that of the general medical patients; interestingly, it made little difference whether elderly patients were admitted to a geriatric or general medical ward. The most common complications among geriatric patients in

this study in decreasing order of frequency were respiratory and urinary infections, acute confusion, falls, pressure sores, drug reactions and diarrhea.²

Table 1. — Relative complication rate in hospitalized patients.

Group	# of admissions	# of admissions with complications	% of complications
1. Acute care geriatric ward	169	121	72
2. Long-stay patients	50	40	80
3. General medical ward (all patients)	193	68	35
4. General medical ward (pts. over 70 yr.)	37	22	60

Data from Rosin, J.J. and Boyd, R.V.: Complications of illness of geriatric patients in hospital. *J. Chron. Dis.* 19:307-313, 1966.

In 1965 Dr. William Reichel prospectively monitored 500 consecutive patients over 65 years old admitted to a medical service and he noted that 146 patients suffered 193 hospital-related complications for an overall incidence of approximately 30 percent (Table 2). The types of complications occurring most frequently included reactions to drugs and procedures, accidents and trauma (primarily falls) and major psychologic decompensation. In addition, Reichel reported a large number of intercurrent illnesses, the majority of which were the result of immobilization and being confined to bed.³

Major complications of hospitalization • It is instructive to look at the major categories of complications which can befall the hospitalized elderly, both iatrogenic and incidental, with a view towards potential methods of prevention. In many cases it is difficult to clearly separate the relative contribution of iatrogenesis to complications from intrinsic factors of normal and pathologic aging and unusual reactions to illness which predispose the elderly to adverse occurrences when hospitalized.

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Reactions to drugs • In a recent major overview study of iatrogenic disease, reactions to drugs accounted for 40 percent of adverse reactions of hospitalized patients, 19 percent of which were considered to be a major threat to life.⁴ The drugs particularly prone to cause complications included cardiac drugs (nitrates, digoxin, antiarrhythmics) and anticoagulants, the latter accounting for a large proportion of major reactions. There is little doubt that the elderly are at a decidedly greater risk of drug reactions. The Boston Collaborative Drug Surveillance Program revealed a uniform increase in incidence of reactions with age, with a peak incidence of 33 percent in the 66-75 year age group. Other studies have documented a risk of adverse drug reactions in the hospital approximately twice as high in those over 70 years old as in the general hospital population.⁵ Factors leading to increased risk in the elderly include altered pharmacokinetics (altered absorption, binding, distribution, excretion) and pharmacodynamics, multiple drugs, and an increasingly recognized failure to make appropriate dosage adjustments in elderly patients. Effective prevention of drug reactions necessitates frequent review of all drugs ordered, by the physician coordinating care, for potential adverse interactions and proper dosages. One study has documented a breakpoint of six total drugs ordered concurrently, over which the incidence of complications increases dramatically, and thus an important goal in care of the elderly is elimination of all unnecessary drugs when possible.⁶ Finally, the physician should observe carefully for side effects of drugs, particularly confusion and oversedation in elderly patients as this type of reaction tends to produce serious secondary morbidity.

Table 2. — Complications of hospitalization and intercurrent illnesses in 500 elderly patients.

Reactions to medications	54
Reactions to procedures	31
Accidents and Trauma	61
Hospital induced major	
psychologic decompensation	19
hospital acquired infections	17
Total	193 (146 patients)
Intercurrent disease processes	44

Adapted from Reichel, W.: Complications in the care of five hundred elderly hospitalized patients. *Journal of the American Geriatric Society*. 13:973, 1965.

Reactions to procedures • In the overview study mentioned previously, reactions to diagnostic and therapeutic procedures made up 35 percent of all adverse reactions, with 28 percent of major impact.⁷ While invasive procedures such as cardiac catheterization and angiography of all types carry considerable

risk for all patients, certain relatively simple procedures can represent substantial hazards to the elderly. Intravenous therapy can rapidly result in inadvertent volume overload due to diminished cardiac reserve, and the exaggerated antidiuretic hormone (ADH) secretion in the elderly in response to stress predisposes these patients to dilutional hyponatremia.⁸ Urinary tract catheterization, with its attendant risks of infection and catheter dependency can result in rather marked functional impairment in the aged. Even the barium enema, a relatively safe and commonly performed radiographic procedure, by virtue of the rigorous cathartic prep required can initiate a cycle of dehydration and weakness in frail patients which may severely stress other homeostatic mechanisms.⁹ There are many other procedures of potential harm. Prevention of complications of these procedures requires careful consideration of benefit versus risk, and then the specific combination and sequence of procedures to be performed. In many cases diagnostic zeal may need to be tempered with the realization that procedures need to be scheduled over a longer time interval, if possible, to allow time for rest and recovery.

Falls and trauma • The elderly are at special risk of falling when hospitalized, due to the usual causes of falls in the elderly including loss of postural control and gait problems in addition to liability imposed by their underlying illness, medications, acute confusion, complex diagnostic and therapeutic procedures and being transposed to an unfamiliar environment.¹⁰ Berry, et al., in a recent study from a Canadian long-term care geriatric hospital documented a high incidence of falls in transfers of patients from bed to wheelchair or stretchers and vice versa.¹¹ Other studies have documented a high incidence of falls from bed at night. In any case, the majority of falls in hospitalized patients occur in their rooms within the immediate vicinity of their beds, the area of the hospital where they are most likely to be left unattended. Optimal medical, rehabilitative and psychiatric care with rapid recovery and restoration of function to patients is the single most important preventive measure of falls in the hospitalized elderly. As sedation and confusion, especially nocturnal, are common precipitating causes of falls, the physician should be alert to subtle confusion and drug interaction. Of particular importance is an overall hospital commitment to a safe environment including effective follow-up of falling incidents and training of all patient-care staff in safe transfer procedures. Important nursing and environmental factors include use of high-low beds (with bed down when patient unattended), urinals and bedpans within reach, non-skid floor surface with removal of all potential obstructions, night lights, adequate side rails, and judicious, ethical use of restraint. In addition, it is well to remember the value of a family com-

panion or privately obtained sitter for the high risk patient.

Intercurrent illnesses • The occurrence of intercurrent illnesses while hospitalized represents a risk for all patients though, again, the liability of the elderly is considerably greater. A number of significant intercurrent illnesses including aspiration pneumonia, pulmonary embolism, decubitus ulcer, fecal impaction and urinary retention are either partially or wholly the result of reduced activity and immobilization. In addition, nosocomial infections such as urinary tract infections and sepsis are frequently the indirect result of medical interventions including genitourinary instrumentation, peripheral or central venous catheterization or broad-spectrum antibiotic therapy. Although some intercurrent illnesses may be unpreventable, early mobilization, when possible, of elderly patients as well as attention to nursing details of frequent turning and careful attention to skin, bowel and bladder status, and hydration can allow early corrective measures to be taken. Specific preventive techniques such as the use of low-dose heparin for venous thrombosis should also be considered in selected circumstances.¹²

Psychological consequences of hospitalization • Hospitalization is an unpleasant prospect for most rational individuals, but for the elderly patient admission to a hospital often represents a perceived and actual threat to his mental and emotional well-being. Anxiety and depression are almost universal reactions to hospitalization and it is reasonable to assume some degree of fear of permanent disability or death, which is magnified by an increasing complexity of tests and procedures, and confusing hospital routine. Fear of permanent role loss, whether it be that of wife or husband or even caretaker of a beloved pet can significantly effect the elderly patient's overall sense of well-being and his subjective response to illness.¹³

Perhaps the most devastating psychological complication of hospitalization is the acute confusional state, an important cause of morbidity and a contributing factor to mortality in otherwise non-fatal illness. The etiology of acute confusion in the ill elderly are multiple, including almost any serious acute illness, drug effect or simply the act of transferring a patient to the hospital environment, the "relocation effect".¹⁴ A detailed consideration of this complex clinical problem is outside the scope of this discussion but the reader is referred to the referenced chapter by Cape for an excellent review.¹⁵

All hospitalized patients experience miscellaneous deprivations, but these seemingly trivial problems are felt most acutely by the elderly. Paradoxically, nutritional deprivation is a common accompaniment of hospitalization for the geriatric age group

due to actual unpalatability of institutional food in addition to the sometimes careless manner in which food is presented or in which assistance with eating is rendered. Social isolation from family and friends because of restrictive visitation policies, and especially restriction of grandchildren can significantly enhance depression and loneliness.¹⁶

The hospital is a dependency producing environment. For elderly patients the short-term inability to feed or bathe oneself or incontinence can evolve to permanent functional dependence unless special care is taken to assist the aged patient in regaining competence through the use of appropriate rehabilitative care. Additional useful preventive strategies in avoiding psychological and emotional complications of hospitalization include encouraging frequent visits by family and friends, as well as special efforts by the physician and nursing staff to provide emotional support. It is important to orient the patient to planned diagnostic procedures, and often a careful discussion of the rationale and future plan will lessen anxiety. Finally, early discharge planning with the goal of reducing hospital stay to the minimum time necessary is an important preventive measure in the elderly.

The ultimate prevention of the complications of hospitalization is to keep our patients out of the hospital, and the option of home care should always be considered especially in the case of the frail elderly. The benefits of hospitalization clearly often outweigh the risks, but careful attention to detail is required to minimize the very real hazards which hospital care can represent to our aged patients.

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Sexual function in old age

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There are 30 million American men and women today who are over 60 years of age, and every day another five thousand reach that mark. It is paradoxical that the elderly are so often expected to be sexually inactive. Sex for them is felt to be neither necessary nor possible. Masters and Johnson wrote: "From a psychosexual point of view, the male over age 50 has to contend with one of the great fallacies of our culture. Every man in this age group is arbitrarily identified by both public and professional alike as sexually impaired."¹

Why are negative attitudes about sexual function in old age so widely held? Psychoanalysts tell us that the reason, in part, is due to the persistence of the oedipus complex in all of us. The first time the small boy or girl learns about sexual intercourse, he says to himself, "Yes! Everybody in the world does it but my honorable parents." The continuation of the oedipal complex in all of us — even after we grow up — results in negative feelings and a kind of discomfort at the thought of old people having sex; for the old are an unconscious extension of our own parents.

Another reason for denying the sexuality of the aged is the fear, unwarranted but nevertheless often present, among younger adults that their own sexual abilities will be lost as they age. One way of dealing with this fear is to pooh-pooh the idea that sex is important in the later years.

Finally, our culture's fixation on youth results in a self-fulfilling prophecy for the elderly — that sexual performance declines with advancing years until it vanishes. This erroneous conditioning causes many senior citizens to abandon sex completely. As Comfort stated, the elderly are expected to be invisible, inactive, and sexless.²

Yet every recent medical study proves conclusively that there is no biologic reason why older men and women should not have an active and rewarding

sex life. We know that sex is a major psychological concern in the later years, and is intimately linked to the older person's self-esteem. Again, to quote Masters and Johnson, "The two main requirements for enjoyable sex activity until late in life are, firstly good health, and secondly an interested and interesting partner." Expressed somewhat more poetically, de Beauvoir wrote, "Those who keep this treasure to an advanced age are privileged indeed — sexuality, vitality, and activity are indissolubly linked."³ A bawdy poem adapted by Louis Untermeyer from an ancient Greek anthology titled "Ageless" is even more explicit:

*Now Charito is sixty. But her hair is dark;
her ample bosoms firm and fair;
Her skin is like a young girl's, warm and white;
Her legs and thighs are fashioned to delight.*

*Her years are in her favor, for she knows
Tricks that a novice never could disclose.*

*Yes, she is sixty; but, still full of fire,
She'll do, my friend, whatever you desire.*

In aging, we accept a relative decline of our physical powers; we recognize that, for the most part, our Olympic champions are drawn from men and women in their late teens and early twenties. So it is with sexual power. Masters and Johnson pointed out, "Human sexual response may be slowed by the aging process, but it is certainly not terminated."¹ Despite the obvious fact that the youthful Hercules of the bedroom cannot maintain the same performance with advancing years, many men start worrying secretly about sexual aging some time during their thirties. It is then that they compare their previous peak performance as teenagers and very young adults with their present level of sexual activity. Yet more than seven out of ten healthy married couples over 60 are sexually active, some into their late eighties. And nearly half of all men between 75 and 92 experience satisfactory coitus.

Normal sexual function in the older male •

Masters and Johnson have divided the sexual response cycle into four phases: excitement, plateau,

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orgasm, and resolution. First, there is a significant delay in achieving erection compared with the facility of response of the younger man. The erection may not be as full or demanding as that to which he has previously been accustomed, although completely adequate for full penetration.

Second, with the approach of the plateau phase there is little if any testicular elevation, a negligible amount of scrotal-sac vasocongestion, and minimal deep vascular engorgement of the testes. There is either total absence of, or marked reduction in, the amount of pre-ejaculatory emission (the secretion of Cowper's glands.) When the older man has reached the level of elevated sexual tension perceived as thoroughly enjoyable, he can, and frequently does, wish to maintain this plateau-phase level of sensual pleasure for an indefinite period of time without the irresistible need to ejaculate. By contrast, the younger man tends to drive for early ejaculatory release when plateau-phase levels of sexual tension have accrued. Thus, one of the advantages of the aging process, according to Masters and Johnson, is that control of the ejaculatory demand in the 50-75 year old group is far better than in the 20-40 year old group. Because sexual arousal occurs more slowly, the older man is likely to engage in sexual foreplay at a more leisurely pace, and with greater pleasure for himself and his partner. During penetration, the older man is liberated from the ejaculatory urgency which often restricts the younger man.

Third, in younger men, the ejaculatory phase is divided into a first phase of ejaculatory inevitability in which the ejaculation is felt imminent and can no longer be controlled, and a second phase of emission of semen. The older man may no longer have a first stage of ejaculatory inevitability, or it may be shortened from the two to four seconds of the younger man. Other changes in the older man are reduction of seminal fluid volume from 3 to 5 ml. to 2 to 3 ml. and a reduction in the expulsive force delivering the seminal fluid. It is important to note that these physiologic changes in no way detract from the pleasure the older man derives from his orgasm.

Fourth, the refractory period also lengthens with aging. In the younger man, the refractory period usually lasts only a few minutes before he can return to full erection under the influence of effective sexual stimulation. For the older man, it is usually a matter of hours or even days before return to full erection is possible. In contrast to the younger man, the older man may lose his erection after ejaculation with extreme rapidity. Apart from increased ejaculatory control, the older man may also experience a decline in ejaculatory demand, finding that he needs to ejaculate only on every second or third coital connection.

The question is sometimes asked whether there is a male menopause, i.e., a period in life physically or psychologically comparable to the female cessation

of menstruation and loss of estrogenic hormones. There is no male climacteric analogous to that in women, because hormone loss in men occurs very gradually with age, with wide individual variations. It is rare for men to have specific physiologic symptoms which can be traced directly to lowered androgen levels. This is also true for distinct psychologic symptoms.

Normal sexual function in the older female

• First, there is delay in the development of vaginal lubrication, the analogy of the older man's delay in achieving full erection. Thus, according to Masters and Johnson, it may take up to four to five minutes of undemanding sexual play before any significant degree of lubrication develops for the older woman. Due to the natural involution of ovarian function with aging and corresponding reduction of sex-steroid levels, the older woman's vaginal capacity constricts and the vaginal walls become thin and atrophic. This also interferes with lubrication. Vaginal elasticity is reduced in the older woman, as is the elasticity of the labia majora and minora, important in permitting separation and retraction of these structures prior to coital penetration.

Second, compared to that of the younger woman, the orgasmic phase of the older woman is significantly shortened. The number and strength of uterine contractions in the older woman during the orgasmic phase is reduced. Thus only one or two uterine contractions take place compared with three to five in the younger woman. In a number of older women, the uterus may go into spasm lasting a minute or more during orgasm. This is experienced as lower abdominal pain, occasionally radiating into the vagina. Such uterine spasms indicate an excessive involution of ovarian steroids, and can be relieved by replacement therapy.

Finally, resolution-phase return of the pelvic viscera to the unstimulated baseline after orgasmic experience is rapid, more so than in the younger woman.

Sexual interest and activity in older men and women

• Pfeiffer studied elderly women whose health, intellectual status and social functioning were well preserved. He found that only 33 percent as compared to 80 percent of the men, admitted to continued sexual interest. Only 20 percent, as compared with 70 percent for the men, still reported regular sexual activity.⁴ These differences between the sexes may be due to women outliving men by several years. The large surplus of elderly widows means that for many, the opportunity for sexual relations has vanished. In the absence of stimulation, sexual interest will wane and eventually disappear. There is no basis for the myth that indulgence in sexual activity early in life leads to a "flaming-out" of sexual interest and

activity later in life. Rather, the reverse is true; an active, gratifying sex life continues into the later years, provided the opportunity is there. It is probable that many elderly women who still experience erotic feelings may be driven to masturbation, but as inquiry is rarely made about autoerotic practices in this age group, the prevalence of masturbation is unknown.

Common health problems interfering with sexual function • As previously stated, in the post-menopausal woman, the vaginal wall atrophies, elasticity is reduced, and lubrication is slow and scanty. The dyspareunia which develops after the menopause can be corrected by replacement therapy with estrogen and progesterone, coupled with the more liberal use of a water-soluble lubricant such as KY jelly.

Another problem is that sexual intercourse in the older woman may lead to urinary infection through massage of bacteria into the paraurethral glands and thence to the bladder, causing cystitis. Infections thus arising during sexual intercourse are manifested 36 hours later. The condition is caused by prolonged coital friction and probably inadequate personal hygiene. It is the analog of honeymoon cystitis and is easily prevented. Older women should be advised to drink plenty of water, and to urinate freely after sexual intercourse so as to flush out the lower urinary tract.

Hysterectomy and prostatectomy • Hysterectomy is a common event to befall an older woman. Ordinarily, hysterectomy has no effect upon sexual desire or performance. However, in a neurotic woman, the unconscious perception of being mutilated may adversely affect her sexuality. Psychotherapy may therefore be needed to resolve this conflict.

Transurethral resection of the prostate and suprapubic prostatectomy do not affect potency. Total prostatectomy through the perineal route results in impotence. In men who have had prostatectomies of all kinds, about 70 percent remain potent. After prostatectomy, the semen is deposited in the bladder, leading to an alteration of orgasmic sensation. This so-called "dry ejaculation" may cause anxiety and even loss of potency unless adequately explained and reassurance provided.

Diabetes mellitus • The most common cause of organic impotence is diabetes mellitus. Fifty percent of male diabetics are impotent before age 60. This is probably due to diabetic neuropathy. Diabetics with sexual dysfunction may exhibit classical symptoms of neurologic damage, e.g., atonic bladder, diabetic enteropathy, neuropathic ulcer, and orthostatic hypotension. Potency depends upon the integrity of the autonomic nervous system, which is often impaired in diabetic neuropathy. It is more difficult to evaluate

the effect of diabetes on female sexuality, since they have no obvious physical indicator of arousal such as erection.

Heart disease • Hellerstein and Friedman studied the sexual activity of men after recovery from an acute myocardial infarction. They reported that if the patient could perform exercise at levels of vigorous walking and other special activities without symptoms of abnormal pulse rate, blood pressure, or EKG changes, it was generally safe to recommend the resumption of sexual activity.⁵ During orgasm, the energy output is at the rate of six calories per minute. The oxygen cost in sexual intercourse is equivalent to that used in climbing a flight of 20 stairs, or walking briskly. The heart rate varies from 90-150 beats per minute, with the average 120, or about the level for light or moderate exercise.

Patients with heart disease may have a fear of dying during sexual intercourse, or perhaps having another heart attack or stroke. Figures are hard to come by, but a conservative estimate is that only one percent of coronary deaths occur during sexual intercourse. Thus after myocardial infarction, if no symptoms occur no restriction is necessary, and sexual relations may resume in about twelve to sixteen weeks. If any advice need be given, it is that the patient refrain from cheating. Fear of discovery, excitement, or anxiety about performing well with a new partner may result in excessive adrenalin secretion, an important etiological factor in coronary attacks. Anxiety over illicit sexual relations will increase cardiac stress and thus the risk of a myocardial infarction.

Miscellaneous conditions in the elderly • Obesity, arthritis, spondylitis, and chronic neurologic disability such as hemiplegia or paraplegia may, through pain, mechanical difficulty or deformity, interfere with sexual relations. Lower limb amputations for peripheral vascular disease and its consequences are also common in the elderly, presenting both mechanical and psychological problems.

Most overt sexual displays in books, films, and plays tend to dwell on the young and the beautiful, omitting the aged. Further, the idea of deformed, maimed, elderly unattractive bodies enjoying sexual activities may lead to feelings of distaste and even revulsion in the physician, and be difficult to cope with. Patients, too, may have problems in accepting the personal mutilation of mastectomy, amputation, or colostomy which alter their perceptions of their body-image, so that they cannot believe themselves still attractive to their sexual partner.

Drugs and medications • Misuse of drugs can also seriously impair potency. Just as in the young, alcohol in the elderly may increase desire but reduce

performance. It is also important to remember that no class of antihypertensive drug seems free from negative effects upon sexual function. Many psychotropic drugs also impair sexual function, with thioridazine apparently the worst offender.

Psychological problems affecting sexual function in old age •

The older man is prone to complain that his potency is waning. He feels the desire is there, but the means for gratifying it is weakening and laments "I have women on my mind, but never on my knee." He may blame his partner for being less beautiful and attractive because she is growing older, a classic example of projection. Jealousy is also common; those aging men who cannot hold or satisfy their partners have to be increasingly watchful lest others supersede them in bed. It is also a fairly common experience that those who are growing old may leave their partners for new ones, seeking to break the monotony of a stale and repetitious sexual relationship. The new partners are usually much younger and may be from a lower socio-economic level, but they are more stimulating sexually. The woman is not frigid any more and the man is once again sexually potent as long as the new partner is there. This is the reason for many seemingly incomprehensible second or late marriages.

With aging, sexual libido undergoes some rather characteristic changes. De Beauvoir wrote, "Even when the aged man is still capable of normal sexual activity, he often seeks indirect forms of satisfaction, even more so if he is impotent. He takes pleasure in erotic literature, licentious works of art, dirty stories, the company of young women and furtive contacts; he indulges in fetishism, sado-masochism, various forms of perversion, and, particularly after the age of eighty, in voyeurism."³ The well-known preference of some older men for very young girls has been immortalized in Vladimir Nabokov's novel "Lolita". Conversely, there are probably just as many instances of aging women seducing young boys, but these are rarely publicized.

Some shift of libido away from the genitals occurs in aging, with displacement on the alimentary tract. With aging, there is normally an increased enjoyment of the body's vegetative functions. Appetite, digestion, excretion, and sleep become increasingly rich experiences. Thus, the heightened enjoyment of food during an epoch when less is needed, is a temptation old people must resist to avoid that obesity which is so common in later life, and which reduces both sexual attractiveness and sexual activity.

Older people are also often preoccupied with their bowel function. Television commercials are fond of showing how the springy step of the drooping oldster is restored after a good evacuation achieved

with the aid of the latest patent nostrum. This libidinal shift from the genitals to the alimentary tract may help explain the hypochondriasis of the elderly, expressed as fears of cancer, ideas that the bowels never work properly, and even delusional ideas centering around inner decay and disintegration. Among senior citizens, scatological humor replaces the genital jokes heard in young male company.

Where an old person previously active sexually reports a decline or disinterest in sex, the possibility always exists that such decline may be a symptom of depression. Because depression is so common in the elderly and furthermore is relatively under-diagnosed, it should always be thought of as a possibility where sexual desire and performance declines in the absence of any somatic cause.

Aphrodisiacs: drugs alleged to improve sexual desire and activity •

The decline of potency in old age has resulted in the development of a host of questionable remedies. Many of these go by lurid names such as "Mexican Spanish Fly", "Mad Dog Weed", "Super Nature Tablets", "European Love Drops", and so forth. Some of these preparations contain drugs with potentially dangerous side effects such as cantharides, strychnine, yohimbine, and ginseng root. Replacement therapy with testosterone is yet another recommended treatment, totally useless and even dangerous unless there is a proven deficiency of the hormone, a very rare condition. Among illegal drugs, marijuana, cocaine, and methaqualone are used to enhance the orgasm. Fortunately, these substances are seldom used in the elderly. Those offering aphrodisiacs to the elderly are quacks who seek to capitalize on the myth of the Fountain of Youth, to which every older person is to some degree vulnerable.

Counseling the older patient on sexuality •

Kinsey in studying older people found that those showing a decline in sexual interest appeared "to be affected by a psychological fatigue, a loss of interest in repetition of the same sort of experience, an exhaustion of the possibilities for exploring new techniques, new types of contacts, new situations."⁶

The physician needs to educate himself to accept men and women of all ages as sexual beings, and to reassure his elderly patients that age per se is no barrier to a full and gratifying sex life. In this regard, it should be noted that Butler has described human sexuality as having true developmental potential.⁷ In youth, sex is urgent and explosive, with genital sensuality and procreation as its major goals. It is intimately linked with the expression of strength, prowess, and independence. This is the first language of sex, interpreted to us through the work of Kinsey, Masters and Johnson, and others.

There is however, a second language of sex, which is learned, rather than instinctive. It depends upon

the ability to recognize and share feelings in words and actions, and to achieve a mutual tenderness, delicacy, and thoughtfulness as the years advance. A 16th century sonnet written by Pierre de Ronsard to Helen, Madame de Surgeres evokes for us the magic of the second language of sex and the mood of old lovers,

*When you are old, and in the candle light
Sit spinning by the fire at close of day,
You'll sing my songs in praise of you, and say:
"Thus Ronsard sang, while still my eyes were bright".*

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Some considerations of bioethics in geriatrics

Alfred H. Lawton, M.D., Ph.D.

The fundamental ethical issues troubling mankind, such as love, truth, family relationships, suffering, illness, death, and man's identity and place in the universe have not altered since the beginnings of recorded history. The Biblical patriarchs, the Greek philosophers, and the Oriental wise men were considering these topics thousands of years ago.

Only a few of these topics are pertinent to those health practitioners who deal with aging people and with elderly patients. These issues include organ transplantation, human experimentation, behavior modification, extension of life, dying and death, and physician-patient relationships. Space will only permit superficial examination of a few of these important subjects.

Recently, a medical student was heard idealistically espousing absolute honesty in physician-patient relationships. His talk went well until he introduced the topic of the use of placebos in therapy and in research. Then he found himself confounded by the same problems that have troubled all physicians who have preceded him. Hippocrates and his associates could not reveal the full facts of their therapy to their patients. They had few active pharmaceutical agents and had to rely almost entirely upon their bedside manner, patient rapport, magic, religion, and the faith these engendered to achieve beneficial results.

Today there still exists this necessity to choose between full truth and the effectiveness of the placebo or of a nearly inert medication. There is danger that the value of the medication would diminish if the patient were fully aware of the physician's doubts as to its value. Similarly, total truthfulness would be limiting where placebos are essential components of drug evaluation research which utilizes single and double blind and crossover testing techniques. As the

student discovered, there is no easy or single answer to the ethical problem of the quality and quantity of truthfulness that should prevail between the doctor and his patient.

To further complicate this issue, recent research indicates that mechanisms are stimulated in the mind-brain complex by the patient's reliance upon the physician and his therapy even though the treatment consists entirely of inert medications. The physiologic basis for the observed benefits is that faith stimulates the release of endorphins by certain nerve cells. These liberated neurohormones trigger the body's healing processes. This conforms to the well known fact that the body heals itself. The physician only seeks to make the situation optimum for the healing process to occur and to protect the patient from further complicating damage.

Although this information emanating from research on the nervous system is fascinating, it should not detract us from the subject which was truth. Thinking people have long tried to define this word. Henry James,¹ in his essay, "The Meaning of Truth," suggests that the successful working of an idea is a sign of its truth. By this definition a successful placebo might then be an honest treatment. This would be a verbal truth to the philosophers who seem to have agreed that there are two kinds of truth. To them a verbal truth is an attribute of speech. Its limitations shift with the evolution of thought and as great thinkers play games with words. The laws of nature are the source of the other form of truth. Natural truth is absolute in-so-far as the laws of nature have been understood by mankind.

Humpty Dumpty in Lewis Carroll's,² "Through the Looking Glass," had the correct approach to verbal truth when he said, "When I use a word, it means just what I choose it to mean, neither more nor less... The question is which is to be the master, that is all."

Truth in the practice of gerontology and of geriatrics has other troublesome aspects. Frequently, the health personnel's actions speak louder or more effectively than their words. Hopeful statements conflict with anxious or depressed demeanors. A bored attitude can negate all verbal expressions of concern for an elderly person's welfare.

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Also there is frequently a pointless withholding of information from an elderly or a dying patient. Often this is done in a misguided sense of protecting the patient. Whether this withholding is done as the result of apprehension by the health team or in response to demands by well-meaning family members, such a practice of deception can be harmful. The deceit can cause the patient to be unable to actively cooperate in his care and treatment, can prevent the patient from making plans or achieving actions which he would otherwise have accomplished, can cause the patient to imagine that the situation is worse than it really may be, or can stimulate a game of denial played among the health team, the family, and the patient without anyone actually knowing the thoughts or needs of the others.

The truths which the seriously ill, the chronically debilitated, and the elderly patient need and desire are the assurance of continuing concern and of unceasing therapeutic efforts to treat their symptoms and to preserve their comfort. Even the terminally ill patient needs the assurance that the physician, the hospital or nursing home staff, and all of his family members are going to stand by him to the very end. Such patients certainly do not need the isolation and apparent abandonment too often practiced by emotionally troubled staff members and by grieving family in a self-deceiving concept that the patient needs peace and quiet.

Humpty Dumpty's disdain for fixed definitions of words is pertinent to other ethical problems. Various meanings and usage of words and phrases can lead to misunderstandings and failure of communication between health practitioners and patients. Sometimes cultural or educational differences cause patients to use terms describing symptoms or needs that are not understood by professional persons and *vice versa*. These gaps in communication must never be ignored or glossed over. Every effort should be made to find common terminology that will make possible the full understanding needed for correct diagnosis and proper treatment.

In dealing with the aging and the aged, one needs to use simple terms, define the words carefully, and make every effort to be certain that the patient fully understands. Sometimes total understanding can only be achieved by the utilization of a third party, such as a family member or friend, who hears, comprehends, and will see that the directions are followed.

There is much concern expressed about compliance of elderly patients in following their prescribed therapeutic regimens. This failure of compliance is frequently because the professional person giving directions failed to ascertain the patient really understood fully what he was expected to do. Sometimes, the regimen of medication is so complicated that even youthful, fully well individuals have difficulty

comprehending what is to be done. Usually such intricate programs are not necessary. Simplicity of therapy will do much to achieve patient compliance. Simplicity of directions will improve patient-physician relationships, will help prevent over-medication and some of the reversible dementias so produced, and will do much to limit the complications arising from multiple drug interactions.

What the health team member tells the patient is one important facet of truth and understanding; what the health team member says about the patient is quite a different bioethical issue. All health team members have a great tendency to "talk shop". These interprofessional discussions can occur at the coffee bar, in lunch rooms, hallways, lounges and other public and private places. Too often, these are carried on with disregard of the possibility that the conversation may be overheard by family or friends of the patient and may be conveyed realistically, distorted, or with amplification. When the report finally reaches the patient in its new form it may produce irreversible and irreparable misunderstanding and damage.

Equally to be condemned is the practice during grand rounds or consulting rounds of discussing the patient and his condition near the bed or in the ward with the participants behaving as if the patient were not present or were an inanimate object. Yet, the patient is overhearing frightening possibilities, misinterpreting what is being said, or misunderstanding the tenor of the discussion. Too often, the patient is filled with unnecessary apprehension and terror by the failure of professional personnel to remember that they are dealing with human beings and are not practicing veterinary medicine.

Even in the presence of individuals who are the victims of advanced senile dementia and by the bedside of patients in stupor, in coma, or unconscious, only hopeful and optimistic words should be spoken. Nothing adverse or deleterious should be said for sometimes when recovery has unexpectedly occurred it is discovered that the patient heard and understood the remarks that had been made during the worst stages of his illness. It should never be forgotten that hearing is the last of the senses to be lost at the onset of sleep, stupor, coma or prior to death.

Continued communication with an unconscious or dying patient is important even though he does not seem to be capable of comprehension or response. It is possible that such a patient will find sustenance in the optimistic words. More probable, the patient's support comes from the hope conveyed by the attitude being manifest that the sick person is still important and worth caring for.

Dying patients must comprehend the approach of death. There is a physical response to the internal information arising from the deranged homeostatic mechanisms that are a part of dying. Because of this

internal awareness, these patients especially need to hear and to feel the calm, quiet, optimistic, reassuring, and loving expressions from those who care for them.

Medical science is often criticized for its research on organ transplants, for its biochemical and pharmacological studies seeking ways to prolong life, and its preoccupation with finding techniques to postpone the onset of senility. In spite of the carping, most people really welcome the idea of prolonging the physical, psychological, economic, and socially good life. Most people fear the possibility of becoming senile; they have a horror of protracted meaningless terminal treatment, and they fear the process of dying more than death. The living will was developed in an effort to allay these fears. Through the use of living wills, aging persons are striving to be assured that they will not be forced to undergo the indignities of a prolonged vegetative existence. Rightly or wrongly, the elderly feel that these living wills will continue their own control of their person and body until death has occurred.

There is much knowledge but also considerable misinformation among aging persons about the devices and techniques used for resuscitation and prolonging life. This mixture of fact and fancy has produced in the elderly mixed emotions. They fear that these capabilities might not be fully utilized when more of a meaningful life is still possible; and they dread the possibility that these techniques might be used overlong when there remains no possibility for continuing a good life. These older persons are smart enough to know that informed consent is meaningless at the times these heroic devices might be needed if prior planning has not somehow been achieved with their family and physician.

The actual determination between the possibility of recovery to a full and good life and the loss of any utility in being kept alive, for many aged patients is not yet possible. As a result, every physician dreads having to make the decision to discontinue life support systems. He cannot know with absolute certainty when all hope is gone. Since the physician himself is in such a quandry, it is grossly unfair for him to defer this decision about terminating life support systems to a house officer, nurse, or technician. These persons have even less basis for judgment about the patient's health status and less knowledge of the bioethical concepts and legal complications which may relate to the situation.

Cardiopulmonary resuscitation is properly utilized to prevent sudden and unexpected death but it should not be used in most cases of terminal illness where death is expected. Like the other life support systems, its use may violate the person's right to die with dignity. Unfortunately, as with the other life support systems, the legal responsibilities either for

its use or avoidance are at present unclear. As a result the physician, his medical team, and the patient or the members of the patient's family should be in full agreement about the use or non use of emergency and life support systems. The statement of these agreements should always be fully recorded and a notation of what is to be done should appear in both the progress notes and the order sheet in the patient's chart.

Many diseases once considered incurable are now rather easily managed. Other diseases will achieve the status in the near future. Likewise, there are ever changing indications for the use of the various shades of "code blue" or life support measures during emergency situations. Hence, today's decisions about bioethics will not be relevant to tomorrow's medical capabilities. Ethics in patient management can only be based on the specific needs of an individual patient and of the societal values prevailing at that particular moment. In all situations, the rights and dignity of the patient must be supreme. Consent may *never be presumed* in the decision to administer or to withhold treatment. The patient or the family must always be involved in the decision making processes.

Unfortunately, the interests of the individual patient and of society are not always the same. Not only are there ethics that should be considered for the individual but there are also ethics of concern to the aging and the aged collectively. The elderly, as a group, have special social, economic, protective, and safety needs in addition to their health requirements. All require solution.

It is no longer adequate to be concerned with meeting the health needs of one aging patient as seen in the office, hospital, or nursing home. The health profession's concern must include the social, economic, safety, and spiritual needs of not only the individual patient but of the total needs of this segment of society.

Sometimes the needs of the individual and of society conflict, as for example when there are not enough adequate treatment facilities and equipment available or there are not enough economic resources to pay for the care. It is to be hoped that the solution is not to be the military triage system of decision making but that it will continue to be based on the golden rule, doing unto others as you would have done unto you.

Like the concept of truth, all facets of bioethics are not subject to full identification, final absolute definition or total acceptance of a single point of view. As knowledge is gained, medical ethics will alter. Bioethics can never be fixed. Always the choice will be among the various historic, scientific, political, social, behavioral, and philosophical possibilities and probabilities prevailing at that moment in time. There is in bioethics no simple choice between perfection and absolute evil.

To achieve a working personal bioethics for the practice of gerontology and geriatrics, each individual professional person involved has primarily to be a good, honest, concerned and loving person himself. The bioethics of society is totally determined by the ethics of the individuals who compose that society. Equally, the bioethics of gerontology and geriatrics results from the ideals of those who care for the aging and the aged.

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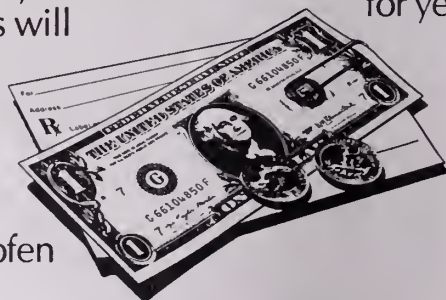
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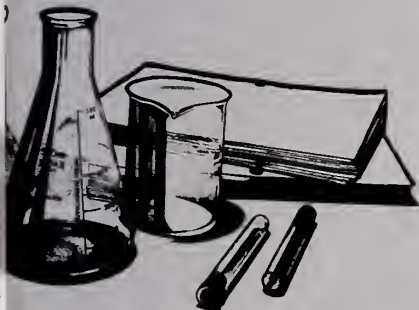
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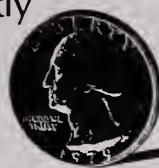
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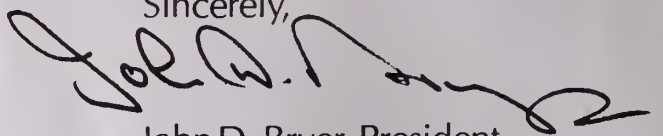
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Relief of mild to moderate pain.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see **WARNINGS**).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see **CONTRAINDICATIONS**). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the **ADVERSE REACTIONS**.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS

Incidence greater than 1%

Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4% to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see **PRECAUTIONS**).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see **PRECAUTIONS**). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecostasia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.


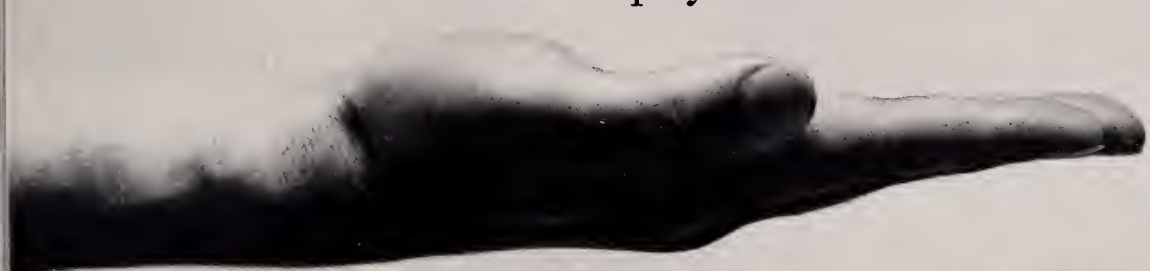
DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

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FLORIDA MEDICAL DEPARTMENTS

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NOTES & NEWS

Drs. Windom and Von Thron appointed to federal government councils

Two Florida Medical Association leaders have been named to important government councils by Secretary Richard Schweiker of the U.S. Department of Health and Human Services.

Robert E. Windom, M.D., of Sarasota, FMA President-Elect, was named to the National Advisory Council on Aging for a term expiring October 31, 1985. The Council makes recommendations to the Secretary relating to the aged on programs administered by the National Institute on Aging.

The Institute was established to conduct and support biomedical, social and behavioral research and training related to the aging process and the diseases and other special problems and needs of the aged.

Meanwhile, Joseph C. Von Thron, M.D., of Cocoa Beach, a Past President of FMA, was named by Secretary Schweiker as Chairman of the national Professional Standards Review Council. The Council advises the Secretary on the administration of the PSRO program that was established by Part B of Title XI of the Social Security Act.

Dr. Von Thron's term runs to January 30, 1984.

Royal college inducts Papper

E. M. Papper, M.D., retired Dean of the University of Miami School of Medicine, was inducted into the Royal College of Surgeons in England as an Honorary Fellow on March 17.

According to the Spring 1982 issue of *Spectra*, a publication of the University of Miami/Jackson Memorial Medical Center, Dr. Papper is only the second American to be honored in this manner. The induction ceremony was followed by a symposium in his honor.

Duke professorship is named for South Florida's Dr. Ingram



Dr. Ingram

James M. Ingram, M.D., Professor and Chairman of the Department of Obstetrics and Gynecology at the University of South Florida College of Medicine, has been honored by the establishment of a professorship at his alma mater, Duke University.

Duke's James M. Ingram Professorship of Gynecologic Oncology was made possible through a fund created several years ago by Mr. and Mrs. Richard H. Vansant of St. Petersburg, both of whom are now deceased. Mrs. Vansant had been a patient of Dr. Ingram when he was in private practice before joining South Florida's charter faculty more than a decade ago.

"I am pleased to learn of the signal honor that has been bestowed upon our Chairman of Obstetrics and Gynecology," Andor Szentivanyi, M.D., Dean of the USF College of Medicine, remarked. "It is richly deserved. The College of Medicine and the community are fortunate to have access to the wisdom, expertise and ability of a physician such as Dr. Ingram."

Dr. Ingram graduated from the Duke School of Medicine in 1943 and completed his residency there. Many years later, he was named a Distinguished Alumnus of Duke.

Duke has begun a search for an eminent physician to fill the new professorship.

FMA Committee on Drug Abuse comments on Dilaudid addiction

The Florida Medical Association Committee on Drug Abuse submitted the following article for publication in *The Journal*:

"During the last six months of 1981, Methadone Treatment Programs licensed by the State through the Department of Health and Rehabilitative Services reported that Dilaudid was a primary narcotic of addiction of 538 clients entering treatment (40% of the total). Heroin addiction amounted to 49%.

"According to the Drug Enforcement Administration in Miami, Dilaudid, 'on the street', is not clandestinely manufactured or obtained through theft, but is prescription Dilaudid.

"Are you doing your share in the fight against drug abuse — or are you part of the problem?"

"Process of aging" seminar is 108th annual FMA meeting scientific program headliner



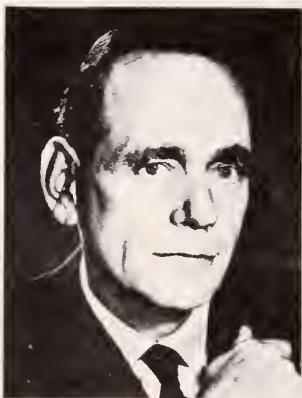
Dr. Pfeiffer

The scientific program is 100% complete and all is in readiness for the 108th Annual Meeting of the Florida Medical Association next month.

The sessions will open at Hollywood's Diplomat Hotel on Wednesday afternoon, May 5, with sessions on internal medicine and trauma, according to Calvin W. Martin, M.D., of Arcadia, Chairman of the Annual Meeting Scientific Assembly. Additional scientific programs will be conducted on Thursday afternoon, all day Friday and Saturday morning, May 6-8.

Theme for the program is "The Process of Aging" and a special seminar on this subject has been arranged for Thursday afternoon under the direction of Andor Szentivanyi, M.D., Dean of the University of South Florida College of Medicine and a member of the FMA Committee on Medical Education.

Prominent Speakers • The theme seminar will feature addresses by Eric Pfeiffer, M.D., Professor of Psychiatry and Director of the Suncoast Gerontology Center at the University of South Florida College of Medicine, Tampa; Robert D. Terry, M.D., Professor and Chairman of the Department of Pathology, Albert Einstein College of Medicine, Bronx, N.Y.; and Eugene A. Stead Jr., M.D., Florence



Dr. Stead

McAlister Professor Emeritus and former Chairman, Department of Medicine, Duke University School of Medicine, Durham, N.C.

Several FMA-recognized specialty groups also plan to address the subject of "aging" in their section programs.

FMA's Annual Meeting offers physicians a convenient opportunity to earn up to 20 hours of CME credit at no cost other than transportation and lodging. There is no registration fee for members of the FMA and/or the American Medical Association, residents, interns and medical students. Nonmembers are subject to a fee of \$25.00.

Category I CME Credit • Application has been made to the Committee on Continuing Medical Education of the Florida Medical Foundation for accredited co-sponsorship of the program and designation of 20 hours of AMA Category I Credit. Other program co-sponsors are the University of South Florida College of Medicine, the University of Florida College of Medicine, and the University of Miami School of Medicine.

As in previous years, the Wyeth AutoTutor teaching machines will be available in the Exhibit Hall for programmed self-instruction in several subjects. Also, Pfizer Laboratories is providing four hours of its popular "Dialogue" programs, all on Friday.

Approximately 50 technical, scientific and educational exhibits will be available for viewing in the Exhibit Hall.

The program:

WEDNESDAY AFTERNOON, MAY 5

SECTION ON INTERNAL MEDICINE

(Co-sponsored by Florida Society of Internal Medicine and Florida Region, American College of Physicians)

Wednesday, May 5 — 1:00 p.m. to 4:15 p.m.

George J. Caranasos, M.D., Gainesville

Program Chairman

"Geriatrics"

"Evaluation of Confusion in the Elderly Patient" — Patricia Barry, M.D., Director, Division of Geriatric Medicine, University of South Florida College of Medicine, Tampa.

"Cell Biology of Human Aging" — Leonard Hayflick, Ph.D., Director, Center for Gerontological Studies and Programs, University of Florida College of Medicine, Gainesville.

"Adaptation to Chronic Illness: The Physician's Role" — Eric Pfeiffer, M.D., Professor of Psychiatry and Director, Suncoast Gerontology Center, University of South Florida College of Medicine, Tampa.

"Prescribing for the Elderly" — George J. Caranasos, M.D., Ruth S. Jewett Professor of Medicine in Geriatrics, University of Florida College of Medicine, Gainesville.

SECTION ON TRAUMA

(Co-sponsored by Florida Committee on Trauma — American College of Surgeons; Florida Chapter, American College of Surgeons; FMA Committee on Emergency Medical Services; and Florida Chapter, American College of Emergency Physicians)

Wednesday, May 5 — 1:15 p.m. to 3:30 p.m.

Arthur L. Trask, M.D., Boynton Beach

Program Chairman

"Trauma Centers 1982: What Are They?

Who Should Go There? Why Have Them Anyway?"

Welcome and Introduction — Arthur L. Trask, M.D., F.A.C.S., Chairman, Florida Committee on Trauma — American College of Surgeons, Boynton Beach.

"Do Trauma Systems Save Lives? The Orange County (Calif.) Experience" — John G. West, M.D., F.A.C.S., Assistant Clinical Professor of Surgery, University of California College of Medicine, Irvine, Calif.

"Trauma System Development: The Missouri Experience" — Frank L. Mitchell, M.D., F.A.C.S., Professor of Surgery, University of Missouri Medical Center, and Chairman, Missouri Committee on Trauma, Columbia, Mo.

"Head and Spinal Cord Trauma: The Florida Neurosurgeons Speak Up" — Donald L. Mellman, M.D., Tampa.

"Categorizing Emergency Departments as Seen by the Florida Chapter, American College of Emergency Physicians" — Daniel E. Lucas, M.D., President, Florida Chapter, American College of Emergency Physicians, Stuart.

"Trauma Centers in Florida: What's Happening in Dade and Monroe Counties?" — David Bernstein, M.D., Chief of the Trauma Service, Jackson Memorial Hospital, Miami, and Member of the South Florida Regional EMS Council.

Panel Discussion and Questions and Answers

Moderator: Arthur L. Trask, M.D.

Panelists: John G. West, M.D.

Frank L. Mitchell, M.D.

Donald L. Mellman, M.D.

Daniel E. Lucas, M.D.

David Bernstein, M.D.

THURSDAY AFTERNOON, MAY 6

SECTION ON RHEUMATOLOGY

(Co-sponsored by Florida Society of Rheumatology)

Thursday, May 6 — 1:00 p.m. to 5:00 p.m.

Mark P. Ettinger, M.D., Stuart

Program Chairman

Welcome and Introduction — Mark P. Ettinger, M.D., Program Chairman, Florida Society of Rheumatology, Stuart.

"Pathogenesis of Hyperuricemia and Gout" — William N. Kelley, M.D., John G. Searle Professor and Chairman, Department of Medicine, University of Michigan Medical Center, Ann Arbor, Mich.

"Clinical Management of Hyperuricemia and Gout" — William N. Kelley, M.D., Ann Arbor, Mich.

"Calcium Induced Arthritis" — Roy D. Altman, M.D., Professor of Medicine, University of Miami School of Medicine, Miami.

"Interpretation of Laboratory Tests in the Diagnosis of Arthritis and Rheumatic Diseases" — Norman Gottlieb, M.D., Professor of Medicine, University of Miami School of Medicine, Miami.

SECTION ON CHEST MEDICINE

(Co-sponsored by Florida Chapter, American College of Chest Physicians, and Florida Thoracic Society)

Thursday, May 6 — 1:00 p.m. to 4:00 p.m.

Mark Snider, M.D., South Miami

Adam Wanner, M.D., Miami Beach

Program Co-Chairmen

"Cardiopulmonary Function at Various Levels of Activity"

"Sleep Disordered Breathing" — James W. Wynne, M.D., University of Florida College of Medicine, Gainesville.

"Cardiac Exercise and Stress Testing" — James Margolis, M.D., Cardiac Catheterization Laboratory, South Miami Hospital, Miami.

"Pulmonary Exercise Physiology" — Norman L. Jones, M.D., McMaster University Health Science Center, Hamilton, Ont.

**SECTION ON ORTHOPEDIC SURGERY
(SECTION I)**

(Co-sponsored by Florida Orthopedic Society)

Thursday, May 6 — 1:30 p.m. to 5:00 p.m.

John F. Lovejoy Jr., M.D., Jacksonville

Program Chairman

President's Remarks — Joseph C. Flynn, M.D., President, Florida Orthopedic Society, Orlando.

"The Treatment of Unstable Fractures of the Tibia and Fibula with Flexible Medullary Wires" — Kurt Hasenhuettl, M.D., West Palm Beach.

"Trials and Tribulations of Closed Intramedullary Nailing" — Gwin Murray, M.D., Maitland.

"Spinal Dysraphism" — Peter L. Meehan, M.D., Atlanta, Ga.

"Alignment of Components in Total Knee Arthroplasty" — Raymond E. Bellamy, M.D., Tallahassee.

"Bilateral Simultaneous Total Knee Arthroplasty" — James T. Rogers, M.D., Bradenton.

"Arthroscopic Surgery for the Treatment of Osteoarthritis" — Melvyn G. Drucker, M.D., North Miami Beach.

"Tension Band Stabilization of Hand Fractures" — Lex Simpson, M.D., Resident, and Robert J. Belsole, M.D., University of South Florida College of Medicine, Tampa.

SECTION ON NEONATAL-PERINATOLOGY

(Co-sponsored by Florida Society of Neonatal-Perinatologists)

Thursday, May 6 — 1:30 p.m. to 5:00 p.m.

Ronald N. Goldberg, M.D., Miami

Program Chairman

"Developmental Problems of Prematurity"

"Management of the Tiny Baby" — Keith S. Kanarek, M.D., Assistant Professor of Pediatrics, University of South Florida College of Medicine, Tampa.

"Intraventricular Hemorrhage in the Preterm Infant" — Emmalee Setzer, M.D., Assistant Professor of Pediatrics, University of Miami School of Medicine, Miami.

"Retrolental Fibroplasia: 1982 Update" — John T. Flynn, M.D., Professor of Ophthalmology, University of Miami School of Medicine, Miami.

"Sudden Infant Death: Developmental Aspects and Management" — Tilo Gerhardt, M.D., Associate Professor of Pediatrics, University of Miami School of Medicine, Miami.

"Factors Influencing the Ultimate Developmental Outcome of the High-Risk Neonate" — Charles R. Bauer, M.D., Associate Professor of Pediatrics, University of Miami School of Medicine, Miami.

SEMINAR ON THE PROCESS OF AGING

(Sponsored by FMA Committee on Medical Education)

Thursday, May 6 — 2:00 p.m. to 4:00 p.m.

Andor Szentivanyi, M.D., Tampa

Program Chairman

Introduction — Andor Szentivanyi, M.D., Dean, University of South Florida College of Medicine, and Member, Florida Medical Association Committee on Medical Education, Tampa.

"Health Care of the Elderly: The New Frontier" — Eric Pfeiffer, M.D., Professor of Psychiatry and Director, Suncoast Gerontology Center, University of South Florida College of Medicine, Tampa.

"The Neurobiology of Aging and Senile Dementia" — Robert D. Terry, M.D., Professor and Chairman, Department of Pathology, Albert Einstein College of Medicine, Bronx, N.Y.

"The Changes Which Occur in a Doctor When He Commits Himself to the Continuing Care of the Elderly Who Have Many Diseases" — Eugene A. Stead Jr., M.D., Florence McAlister Professor Emeritus and former Chairman, Department of Medicine, Duke University School of Medicine, Durham, N.C.

SEMINAR ON MEDICAL MALPRACTICE PREVENTION

(Co-sponsored by Florida Physicians' Insurance Reciprocal)

Thursday, May 6 — 4:30 p.m. to 6:30 p.m.

James W. Walker, M.D., Jacksonville

Program Chairman

"Introduction to Florida Medical Malpractice Problem" — Vernon B. Astler, M.D., Chairman, Florida Physicians' Insurance Reciprocal, Boynton Beach.

"What We as Physicians Do to Get Sued and the Prevention of Suits" — Robert S. Brittain, M.D., President, Medical Liability Consultants Program, Inc., Denver, Colo.

"How Do You Win?" — Robert S. Brittain, M.D., Denver, Colo.

"How to Make a Cheap Suit Expensive — Fighting Too Long, Failure to Cooperate, Etc." — Robert S. Brittain, M.D., Denver, Colo.

FRIDAY MORNING, MAY 7

SECTION ON PEDIATRICS

(Co-sponsored by Florida Pediatric Society)

Friday, May 7 — 8:00 a.m. to 10:45 a.m.

Thomas M. Zavelson, M.D., Gainesville

Program Chairman

"Common Problems in Pediatric Gastrointestinal Disease: Medical and Surgical Approaches"

"Gastroesophageal Reflux" — Joel Andres, M.D., Assistant Professor and Chief, Division of Pediatric Gastroenterology, University of Florida College of Medicine, Gainesville.

"Recent Surgical Advances in Pediatric Gastrointestinal Disease" — Charles Lankau, M.D., Chief of Surgery, Variety Children's Hospital, Miami.

"Recurrent Abdominal Pain in Children" — Doug Sandberg, M.D., Miami.

Roundtable Discussion/Questions — Pediatric Gastrointestinal Disease

Participants: Joel Andres, M.D., Gainesville

Charles Lankau, M.D., Miami

Doug Sandberg, M.D., Miami

SECTION ON GASTROENTEROLOGY

(Co-sponsored by Florida Gastroenterologic Society)

Friday, May 7 — 8:00 a.m. to 10:45 a.m.

Jamie S. Barkin, M.D., Miami

Program Chairman

"Inflammatory Bowel Disease Update"

"Differential Diagnosis of Inflammatory Bowel Disease" — Chester Cassel, M.D., Clinical Professor of Medicine, University of Miami School of Medicine, and Senior Attending Physician, Cedars of Lebanon Hospital, Miami.

"The Role of Radiological Studies in Inflammatory Bowel Disease" — Robert Feltman, M.D., Chief of Radiology, Cedars of Lebanon Hospital, Miami.

"Pharmacotherapy Update" — Howard Manten, M.D., Instructor in Medicine, University of Miami School of Medicine, Miami.

"Rectal Preservation Operations in Inflammatory Bowel Disease" — Donald Buckner, M.D., Professor of Surgery and Chief of Pediatric Surgery, University of Miami School of Medicine, Miami.

"Cancer Surveillance in Inflammatory Bowel Disease" — Arvey I. Rogers, M.D., Professor of Medicine, University of Miami School of Medicine, and Chief of Gastroenterology, Veterans Hospital, Miami.

SECTION ON EMERGENCY MEDICINE

(Co-sponsored by Florida Chapter,

American College of Emergency Physicians)

Friday, May 7 — 8:00 a.m. to 10:45 a.m.

Martin Arostegui, M.D., Miami

Program Chairman

"Critical Care Medicine in a Private Hospital Setting" — Martin Arostegui, M.D., Miami.

"Advanced Cardiac Life Support — Review" — Jeffrey Bettinger, M.D., Miami.

"Advanced Trauma Life Support — Review" — Eugene L. Gitin, M.D., Miami.

SECTION ON CHEMICAL DEPENDENCY

(Co-sponsored by Florida Medical Foundation

Committee on Impaired Physicians)

Friday, May 7 — 8:00 a.m. to 10:45 a.m.

John C. Eustace, M.D., Miami

Program Chairman

Welcome — Guy T. Selander, M.D., Chairman, Committee on Impaired Physicians, Jacksonville; and Dolores A. Morgan, M.D., Medical Director, FMA/FMF Impaired Physician Program, Miami.

"Prevention of Impairment in the Professional" — John-Henry Pfifferling, Ph.D., Medical Anthropologist and Founder, Center for the Well-Being of Health Professionals, Chapel Hill, N.C.

"Dealing with Practice Stressors" — John-Henry Pfifferling, Ph.D., Chapel Hill, N.C.

"Preventing Partnership Divorce" — John-Henry Pfifferling, Ph.D., Chapel Hill, N.C.

FRIDAY MORNING AND AFTERNOON, MAY 7

IALOGUE

(Presented through the Courtesy of Pfizer Laboratories)

Friday, May 7 — 8:30 a.m. to 10:45 a.m. and 1:30 p.m. to 4:30 p.m.

(Note: In each Dialogue segment, the guest professor makes an opening statement of 5 to 10 minutes, and the remainder of the hour is devoted to questions and answers about the topic.)

Morning

"Diabetes: What's New in Management" — B. R. Tulloch, M.D., Associate Professor of Medicine, University of Texas Medical School, Houston, Texas.

"Metabolic Factors in Cardiovascular Disease" — B. R. Tulloch, M.D., Houston, Texas.

Afternoon

"Rational Approach to Use of Nonsteroidal Anti-Inflammatory Drugs in Arthritis and Painful Conditions" — Jacques R. Caldwell, M.D., Clinical Professor of Medicine, University of Florida College of Medicine, Gainesville.

"Rational Use of Psychotropic Drugs in the Middle-Age Patient" — Fred Charatan, M.D., Chief of Psychiatry, Jewish Institute for Geriatric Care, New Hyde Park, N.Y., and Associate Professor of Clinical Psychiatry, State University of New York, Stony Brook, N.Y.

"Angina Pectoris — New Concepts/New Treatment" — [Film]

FRIDAY AFTERNOON, MAY 7

SECTION ON THORACIC AND CARDIOVASCULAR SURGERY

(Co-sponsored by Florida Society of Thoracic and
Cardiovascular Surgeons)

Friday, May 7 — 1:00 p.m. to 4:00 p.m.

Franklin G. Norris, M.D., Orlando

Program Chairman

"Experience, Methods and Results of Percutaneous Transluminal Angioplasty" — Andreas R. Gruentzig, M.D., Department of Cardiology, Emory University School of Medicine, Atlanta, Ga.

"Experience with Unusual Cases Involving Percutaneous Transluminal Angioplasty" — Richard Hawkins, M.D., Department of Radiology, University of Florida College of Medicine, Gainesville.

"Pitfalls and Reservations and Subsequent Surgical Intervention Following Percutaneous Transluminal Angioplasty" — Francis Robischek, M.D., Thoracic and Cardiovascular Surgeon, Charlotte, N.C.

"Experience with Combined Surgery and Angioplasty" — Arthur Roberts, M.D., Division of Thoracic and Cardiovascular Surgery, University of Florida College of Medicine, Gainesville.

SECTION ON ENDOCRINOLOGY AND ORTHOPEDIC SURGERY

(Co-sponsored by Florida Endocrine Society and
Florida Orthopedic Society)

Friday, May 7 — 1:00 p.m. to 4:30 p.m.

James E. Vance, M.D., West Palm Beach

Program Chairman

"Aging and Osteoporosis: Cause and Effect?"

"Osteoporosis — Etiology and Natural History" — C. Conrad Johnston Jr., M.D., Professor of Medicine and Chief, Division of Endocrinology, Indiana University Medical Center, Indianapolis, Ind.

Clinical Case Presentations and Discussion — Peter Weissman, M.D., Clinical Associate Professor of Medicine, University of Miami School of Medicine, Miami.

"University of Florida Osteoporosis Diagnostic Service" — Morris Notelovitz, M.D., Associate Professor of Obstetrics and Gynecology, University of Florida College of Medicine, Gainesville.

"Medical Treatment" — C. Conrad Johnston Jr., M.D., Indianapolis, Ind.

"Surgical Aspects" — Arthur C. Burdett, M.D., Orthopedic Surgeon, West Palm Beach, Fla.

SECTION ON PSYCHIATRY (SECTION I)

(Co-sponsored by Florida Council of District Branches
of the American Psychiatric Association)

Friday, May 7 — 1:00 p.m. to 5:30 p.m.

Fred A. Peisner, M.D., Orlando

Program Chairman

"Psychiatric Development From Infancy to Death"

Introduction — Fred A. Peisner, M.D., Program Chairman, Orlando.

"Infant Psychiatry" — Martin Lazoritz, M.D., Clinical Assistant Professor of Psychiatry, University of Florida College of Medicine, Winter Park.

"Child Psychiatry" — Archie A. Silver, M.D., Professor of Psychiatry and Director of Child and Adolescent Psychiatry, University of South Florida College of Medicine, Tampa.

"Adolescent Development Disturbed by Psychiatric Illness" — Melvin S. Wise, M.D., Clinical Associate Professor of Child Psychiatry, University of Miami School of Medicine, Miami.

"Common Psychiatric Problems and Adaptations of Young Adults" — John E. Adams, M.D., Professor and Chairman, Department of Psychiatry, University of Florida College of Medicine, Gainesville.

Panel — Drs. Lazoritz, Silver, Wise and Adams

SECTION ON PATHOLOGY

(Co-sponsored by Florida Society of Pathology)

Friday, May 7 — 1:00 p.m. to 5:00 p.m.

Isaac Cohen, M.D., Miami Beach

Stephen E. Vernon, M.D., Miami Beach

Program Co-Chairmen

"Pathologic Aspects of Dementia" — Robert D. Terry, M.D., Professor and Chairman, Department of Pathology, Albert Einstein College of Medicine, Bronx, N.Y.

"Senescence of the Immune System: Current Concepts" — John Stablien, M.D., Assistant Professor of Medicine, Division of Allergy and Immunology, Department of Internal Medicine, University of South Florida College of Medicine, Tampa.

The Alfred Lewis Award Presentation

"Pathologic Aspects of Aging" — Arkadi Rywlin, M.D., Director, Department of Pathology and Laboratory Medicine, Mount Sinai Medical Center of Greater Miami, and Professor of Pathology, University of Miami School of Medicine, Miami.

SECTION ON ONCOLOGY

(Co-sponsored by Florida Society of Clinical Oncology
and Florida Radiological Society)

Friday, May 7 — 1:30 p.m. to 4:30 p.m.

Lawrence Broder, M.D., Miami

Program Chairman

"Radiation-Drug Interactions" — Gerald Sokol, M.D., Director of Radiation Oncology, Tampa General Hospital, Tampa.

Selected Proffered Papers by Members of the Florida Society of Clinical Oncology.

SECTION ON RADIOLOGY (SECTION I)

(Co-sponsored by Florida Radiological Society)

Friday, May 7 — 1:50 p.m. to 5:00 p.m.

Noel R. Zusmer, M.D., Miami Beach

Program Chairman

Welcome — Robert J. Mandel, M.D., President, Florida Radiological Society, Melbourne.

"Clinical Aspects of Digital Radiography" — Jerome Sheldon, M.D., Associate Professor of Radiology, University of Miami School of Medicine, Miami.

"Future of N.M.R. Imaging" — John Goddard, Ph.D., Adjunct Assistant Professor of Radiology, University of Miami School of Medicine, Miami.

"Interventional Radiography" — Sheldon Roen, M.D., Assistant Professor of Radiology, University of Miami School of Medicine, Miami.

SECTION ON PREVENTIVE MEDICINE

(Co-sponsored by Florida Society for Preventive Medicine)

Friday, May 7 — 2:00 p.m. to 4:00 p.m.

Jorge Deju, M.D., Longwood

Program Chairman

"The Status of Public Health in Florida" — James T. Howell, M.D., Deputy Secretary and Staff Director, Health Program Office, Florida Department of Health and Rehabilitative Services, Tallahassee.

"An Overview of Tuberculosis in Florida: Among the Haitian Population and in School-Age Children" — Clifford H. Cole, M.D., Director of the State Tuberculosis Control Program, Florida Department of Health and Rehabilitative Services, Jacksonville.

SECTION ON DERMATOLOGY

(SECTION I)

(Co-sponsored by Florida Society of Dermatology)

Friday, May 7 — 3:00 p.m. to 5:00 p.m.

Henry W. Menn, M.D., Miami

Program Chairman

Dermatopathology Clinical Pathological Conference

Selected cases of dermatologic problems of interest to practicing dermatologists will be discussed in detail from the clinical pathological standpoint by the members of the Department of Dermatopathology, University of Miami School of Medicine.

Participants: Neal S. Penneys, M.D., Ph.D., Professor of Dermatology

Alexander Kowalczyk, M.D., Assistant Professor of Dermatology

Guest

Participant: Rees B. Rees, M.D., Clinical Professor Emeritus of Dermatology, University of California School of Medicine, San Francisco, Calif.

SATURDAY MORNING, MAY 8

SECTION ON OBSTETRICS AND GYNECOLOGY

(Co-sponsored by Florida Obstetric and Gynecologic Society)

Saturday, May 8 — 8:00 a.m. to 12:00 noon

Allan G. W. McLeod, M.D., Miami

Program Chairman

"The Finding of Asymptomatic Endometriosis at Interim Tubal Ligation" — Gregory L. Eads, M.D., Resident, University of South Florida College of Medicine, Tampa.

"Adenocarcinoma of the Cervix: Review of Shands Teaching Hospital Cases" — Karen L. Ferguson, M.D., Resident, University of Florida College of Medicine, Gainesville.

"Pelvic Exenteration: A 15-Year Experience with 92 Operations" — Moises Lichtinger, M.D., Fellow in Gynecologic Oncology, University of Miami School of Medicine and Jackson Memorial Hospital Medical Center, Miami.

"Post-Coital Sperm Longevity as Related to Sexual Assault" — Randall L. Brown, M.D., Resident, University Hospital, Jacksonville.

"Incompetent Cervix — Experience with Cervical Circage" — Renee Parker, M.D., Resident, University of Miami School of Medicine and Jackson Memorial Hospital Medical Center, Miami.

"Malaria in Pregnancy" — Makbib Diro, M.D., Fellow in Maternal Fetal Medicine — University of Miami School of Medicine and Jackson Memorial Hospital Medical Center, Miami.

"Use of Femur Length to Estimate Gestational Age" — Cynthia G. Brumfield, M.D., Resident, University of Florida College of Medicine, Gainesville.

"Relationship of Barometric Pressure and Phases of the Moon to Premature Rupture of Fetal Membranes" — John J. Marks, M.D., Resident, University Hospital, Jacksonville.

"Conservative Management of Premature Rupture of the Membranes" — Deborah A. Trehy-Cansler, M.D., Resident, University of South Florida College of Medicine, Tampa.

"Developmental Follow-Up of Low Birthweight Babies" — Nancy S. Hardt, M.D., Fellow in Maternal Fetal Medicine, University of Florida College of Medicine, Gainesville.

SECTION ON ORTHOPEDIC SURGERY

(SECTION II)

Saturday, May 8 — 8:30 a.m. to 11:00 a.m.

John P. Lovejoy Jr., M.D., Jacksonville

Program Chairman

President's Remarks — Joseph C. Flynn, M.D., President, Florida Orthopedic Society, Orlando.

"McKeever Arthrodesis for the Painful Hallux" — Stanley A. Riggs Jr., M.D., Rochester, Minn.

"Keller Stone Bunionectomy" — Mario M. Stone, M.D., Miami Beach.

"Degenerative Spondylolistheses" — Mark D. Brown, M.D., Ph.D., and John M. Lockwood, M.D., University of Miami School of Medicine, Miami.

"Postoperative Treatment of Idiopathic Scoliosis with a Bivalved Plastic Orthosis" — Robert S. Roberts, M.D., Orlando; Charles T. Price, Orlando; and Max F. Reddick, M.D., Winter Park.

"Scoliosis Update — Alternative Methods of Treatment" — Max F. Reddick, M.D., Winter Park.

"The Orthoplast Body Jacket in the Non-Operative Management of Scoliosis" — Peter L. Meehan, M.D., Atlanta, Ga.

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGERY

(Co-sponsored by Florida Society of Plastic and Reconstructive Surgeons)

Saturday, May 8 — 8:00 a.m. to 11:00 a.m.

M. Felix Freshwater, M.D., Miami

Program Chairman

"Medical Malpractice Loss Prevention For the Plastic Surgeon"

Speakers: Robert E. White Jr., Director of Claims and Loss Prevention, Physicians Protective Trust Fund, Miami.

Edward N. Winitz, J.D., LL.M., Adjunct Professor of Law and Medicine, Nova University Law Center, Fort Lauderdale, and Member, Sams, Gerstein and Ward, Miami.

Joel R. Wolpe, J.D., Partner, Carey, Dwyer, Cole, Eckhart and Mason, Miami.

SECTION ON DERMATOLOGY

(SECTION II)

(Co-sponsored by Florida Society of Dermatology)

Saturday, May 8 — 8:00 a.m. to 12:00 noon

Henry W. Menn, M.D., Miami

Program Chairman

Selected Clinical and Scientific Presentations on Current Concepts in Dermatology Presented by the University of Miami School of Medicine faculty.

The Normal Fogel, M.D., Memorial Lectureship in Clinical Dermatology

Guest Rees B. Rees, M.D., Clinical Professor Emeritus of
Lecturer: Dermatology, University of California School of Medicine, San Francisco, Calif.

The Wiley Sams, M.D., Lectureship

Guest Jeffrey Callen, M.D., Assistant Professor of Medicine
Lecturer: [Dermatology], University of Louisville School of Medicine, Louisville, Ky.

SECTION ON OCCUPATIONAL MEDICINE

[Co-sponsored by Florida Occupational Medical Association]

Saturday, May 8 — 8:00 a.m. to 11:45 a.m.

F. Layton Bergquist, M.D., Lakeland

Program Chairman

"Occupational Accidents and Their Impact on the Occupational World"

Welcome — F. Layton Bergquist, M.D., Program Chairman, Lakeland.

"Occupational Accidents That Require Major Surgical Intervention" — Anand Rao, M.D., Private Surgeon, Lakeland.

"Psychological Effects on Accident Victims" — Maurie Pressman, M.D., Department of Psychiatry, Horizon Hospital, Clearwater.

"The Accident, The Worker and The Employer" — F. Layton Bergquist, M.D., Clinical Assistant Professor of Comprehensive Medicine, University of South Florida College of Medicine, Lakeland.

SECTION ON ALLERGY AND IMMUNOLOGY

[Co-sponsored by Florida Allergy Society]

Saturday, May 8 — 8:30 a.m. to 12:30 p.m.

Thomas M. Brill, M.D., Gainesville

Program Chairman

Welcome — Richard F. Lockey, M.D., President, Florida Allergy Society, Tampa.

"Allergic Significance of Cypress and Australian Pine Pollens" — Gerald Bucholtz, M.D., Advance Sub-Specialty Resident, Allergy and Immunology, University of South Florida College of Medicine, Tampa.

"Relationship of Pediatric Respiratory Illness to Adult Airway Obstructive Disease" — Elliot F. Ellis, M.D., Professor and Chairman, Department of Pediatrics, State University of New York at Buffalo, N.Y.

"The Allergenic Significance of Melaleuca or Punk Tree" — John J. Stablein, M.D., Assistant Professor of Medicine, Division of Allergy and Immunology, University of South Florida College of Medicine, Tampa.

"Immunologic Aspects of Fixed Drug Eruptions" — Roger W. Fox, M.D., Assistant Professor of Medicine, Division of Allergy and Immunology, University of South Florida College of Medicine and James A. Haley Veterans Administration Hospital, Tampa.

"Troleandomycin (TAO) in the Treatment of Severe, Intractable, Corticosteroid-Dependent Asthma" — Elliot F. Ellis, M.D., Buffalo, N.Y.

"Effects of Passive Smoking on Small Airway Function" — Heinz J. Wittig, M.D., Director of the Allergy Clinic, Ochsner Clinic and Hospital, and Clinical Professor of Pediatrics, Tulane University, New Orleans, La.

SECTION ON PEDIATRIC CARDIOLOGY

[Co-sponsored by Florida Association of Pediatric Cardiologists]

Saturday, May 8 — 8:30 a.m. to 11:00 a.m.

Arthur S. Pickoff, M.D.

Program Chairman

"Developmental Changes in the Biochemistry of the Aorta" — Robert Boucek, M.D., Professor of Medicine and Director, Division of Gerontology, Department of Medicine, University of Miami School of Medicine, Miami.

"Developmental Aspects of Atherosclerosis: A Pediatric Perspective" — Mary Jane Jesse, M.D., Professor and Vice Chairman, Department of Pediatrics, University of Miami School of Medicine, Miami.

"Changes in Cardiac Electrophysiology with Age" — Alan Ezrin, Ph.D., Research Associate Fellow, Department of Pharmacology and Pediatrics, University of Miami School of Medicine, Miami.

"Process of Aging as it Relates to the Pharmacologic Management of Cardiovascular Disorders" — Sharanmeet Singh, M.D., Visiting Assistant Professor, Department of Pediatrics [Cardiology] and Pharmacology, University of Miami School of Medicine.

**SECTION ON PSYCHIATRY
(SECTION II)**

[Co-sponsored by Florida Council of District Branches of the American Psychiatric Association]

Saturday, May 8 — 8:00 a.m. to 12:00 noon

Fred A. Peisner, M.D., Orlando

Program Chairman

Introduction — Fred A. Peisner, M.D., Program Chairman, Orlando.

"Being an Adult" — Philip B. Phillips, M.D., President, Southern Psychiatric Association, Pensacola.

"The Meal Ticket Syndrome: Masked Depression in the Middle Years" — James N. Sussex, M.D., Professor and Chairman, Department of Psychiatry, University of Miami School of Medicine, Miami.

"The Inner Life of the Older Person" — Eric Pfeiffer, M.D., Professor of Psychiatry and Director, Suncoast Gerontology Center, University of South Florida College of Medicine, Tampa.

"Coping and Management of Terminal Illness and Death" — John M. Kulda, M.D., Associate Professor of Psychiatry, Director of Residency Training, University of Florida College of Medicine, Gainesville.

Wrap-up Panel — Drs. Phillips, Sussex, Pfeiffer and Kulda

**SECTION ON RADIOLOGY
(SECTION II)**

[Co-sponsored by Florida Radiological Society]

Saturday, May 8 — 9:00 a.m. to 11:45 a.m.

Noel R. Zusmer, M.D., Miami Beach

Program Chairman

"Unusual Mammographic Presentations of Cancer" — Joel Schneider, M.D., Clinical Assistant Professor of Radiology, University of Miami School of Medicine, Miami.

"Automated Sonography of the Breast" — Victor G. Maturo, M.D., Assistant Professor of Radiology, University of Miami School of Medicine, Miami.

"Pelvic Ultrasound" — Noel R. Zusmer, M.D., Assistant Professor of Radiology, University of Miami School of Medicine, Miami.

SECTION ON NEUROLOGY AND NUCLEAR MEDICINE

(Co-sponsored by Florida Society of Neurology
and Florida Society of Nuclear Physicians)
Saturday, May 8 — 9:00 a.m. to 12:00 noon
Warren R. Janowitz, M.D., Miami Beach
Steven A. Shaivitz, M.D., West Palm Beach
Program Chairmen

"Introduction: New Techniques in Imaging, Positron Emission Tomography, Nuclear Magnetic Resonance and High-Resolution Real-Time Ultrasound" — Warren R. Janowitz, M.D., Assistant Professor of Radiology, University of Miami School of Medicine, Mount Sinai Medical Center, Miami Beach.

"Positron Emission Tomography: Basic Instrumentation and Radiopharmaceuticals" — Peter Kenny, Ph.D., Professor of Radiology, University of Miami School of Medicine, Mount Sinai Medical Center, Miami Beach.

"Neurological Investigation with PET" — Myron Ginsberg, M.D., Department of Neurology, University of Miami School of Medicine, Miami.

"Potential Neurosurgical Applications of PET" — Ross Davis, M.D., Director of Neurological Surgery, Mount Sinai Medical Center, Miami Beach.

"Nuclear Magnetic Resonance (NMR) Imaging: Current Status" — Aldo N. Serafini, M.D., Director, Division of Nuclear Medicine, University of Miami School of Medicine, Miami.

"Non-invasive Carotid Evaluation by Doppler and Real-Time Ultrasound" — Warren R. Janowitz, M.D., Miami Beach.

"Neurology: Malpractice Claims Experience" — Mr. John Robinson, Vice President for Claims, Professional Insurance Management Company (PIMCO), Jacksonville.

SECTION ON PHYSICAL MEDICINE AND REHABILITATION

(Co-sponsored by Florida Society of Physical Medicine
and Rehabilitation)
Saturday, May 8 — 9:00 a.m. to 11:00 a.m.
Solomon Winokur, M.D., Lake Worth
Program Chairman

"Evoked Somato-Sensory Potentials in Physical Medicine and Rehabilitation" — W. T. Lieberman, M.D., Ph.D., Brooklyn, N.Y.

SECTION ON PEDIATRIC SURGERY

(Co-sponsored by Florida Association of Pediatric Surgeons)
Saturday, May 8 — 9:00 a.m. to 12:00 noon
Ronald F. David, M.D., Orlando
Program Chairman

Introduction and Welcome — Ronald F. David, M.D., President and Program Chairman, Florida Medical Association of Pediatric Surgeons, Orlando.

"Protection of the Solitary Testes" — H. Warner Webb, M.D., Peter Stevens, M.D., and Albert Wilkinson, M.D., Jacksonville.

"Primary Resection Without Diversion for Necrotizing Enterocolitis" — Ralph Swank, M.D., Tampa.

"Successful Management of Malignant Hyperthermia" — John Krause, M.D., Jacksonville.

"Congenital Evisceration" — William Richardson, Tampa.

"Ureteropelvic Junction Obstruction in the Newborn" — Charles Lankau, M.D., and Malvin Weinberger, M.D., Miami.

"Foreign Bodies in the Pediatric Tracheo-Bronchial Tree" — Fredrick Ryckman, M.D., Farhat Moazam, M.D., and James Talbert, M.D., Gainesville.

"The Remarkable Dr. Roget" — Hugh Lynn, M.D., Director of Undergraduate Education and Surgery, University of Alabama School of Medicine, Birmingham, Ala.

SECTION ON FAMILY PRACTICE

(Co-sponsored by Florida Academy of Family Physicians)
Saturday, May 8 — 9:00 a.m. to 12:00 noon
Bernard Breiter, M.D., Daytona Beach
Program Chairman

"Expanded Concept of Angina in the Aging — Role of Calcium Antagonists" — Alan B. Miller, M.D., Chief of Cardiology, JHEP Dept. of Medicine, University Hospital, Jacksonville.

"The Family Practitioner's Approach to Psychiatric Problems in the Elderly" — Fred B. Charatan, M.D., Chief of Psychiatry, Jewish Institute for Geriatric Care, Long Island Jewish-Hillside Medical Center, New Hyde Park, N.Y.

"Physiological Changes in Cutaneous Aging" — Neil Fenske, M.D., Associate Professor and Director, Division of Dermatology, University of South Florida College of Medicine, and Chief, Division of Dermatology, Veterans Administration Hospital, Tampa.

"Physical Fitness in the Elderly" — John Warren, M.D., Assistant Professor, Department of Family Medicine, University of South Florida College of Medicine, Tampa.

SECTION ON UROLOGY

(Co-sponsored by Florida Urological Society)
Saturday, May 8 — 9:00 a.m. to 11:00 a.m.
Michael T. Small, M.D., Miami Lakes
Program Chairman

"CT Scanning of the Genitourinary Tract" — Freddie Gargano, M.D., Clinical Professor of Radiology, University of Miami School of Medicine, Miami.

Pyelogram Hour

SECTION ON OPHTHALMOLOGY

(Co-sponsored by Florida Society of Ophthalmology)
Saturday, May 8 — 9:00 a.m. to 12:00 noon

(Note: The Section on Ophthalmology will be presented in the Retter Auditorium of the Anne Bates Leach Eye Hospital/Bascom Palmer Eye Institute, 900 N.W. 17th Street, Miami. Physicians wishing to attend this session should arrange their own transportation.)

Edward W. D. Norton, M.D., Miami
Program Chairman

"Indications for Laser Treatment in Glaucoma" — Elizabeth Hodapp, M.D., Assistant Professor of Ophthalmology, University of Miami School of Medicine, Miami.

"Diagnosis and Management of Macular Disorders in the Aged Population" — J. D. M. Gass, M.D., Professor of Ophthalmology, University of Miami School of Medicine, Miami.

"Endophthalmitis" — William Culbertson, M.D., Assistant Professor of Ophthalmology, University of Miami School of Medicine, Miami.

"Diabetic Retinopathy" — Harry T. Flynn, M.D., Assistant Professor of Ophthalmology, University of Miami School of Medicine, Miami.

SECTION ON SURGERY

(Co-sponsored by Florida Chapter,
American College of Surgeons)

Saturday May 8 — 10:00 a.m. to 12:00 noon

David H. Shapiro, M.D., Clearwater

Program Chairman

"Initial Assessment, Establishment of Priorities, Resuscitation and Care of the Acutely Injured Patient — With Case Presentations" — (Panel)

Participants: Raymond Alexander, M.D., Associate Professor of Surgery, University of Florida College of Medicine, Gainesville.

Arthur Trask, M.D., F.A.C.S., Chairman, Florida Trauma Committee, American College of Surgeons, Boynton Beach.

George Watkins, M.D., F.A.C.S., Associate Professor of Surgery, University of South Florida College of Medicine, and Chief, Surgical Services, Tampa VA Hospital, Tampa.

Jake Goldberger, M.D., Assistant Professor of Surgery and Member of the Trauma Service, University of Miami School of Medicine, Miami.

David Bernstein, M.D., Assistant Professor of Surgery and Director of the Trauma Service, University of Miami School of Medicine, Miami.

SATURDAY AFTERNOON, MAY 8

SECTION ON INTERNATIONAL COLLEGE OF SURGEONS

(Co-sponsored by Florida State Surgical Division,
International College of Surgeons)

Saturday, May 8 — 1:00 p.m. to 3:00 p.m.

Robert H. Hux, M.D., Leesburg

Program Chairman

"The Treatment of Unstable Coronary Artery Disease" — Steven J. Phillips, M.D., Associate Professor of Surgery, COMS, Drake University, Des Moines, Iowa.

"Surgery in the Post-Op Cardiac Surgery Patient" — Steven J. Phillips, M.D., Des Moines, Iowa.

Scientific and educational exhibits

Exhibit hall — 1982

- A-B "Pitfalls in the Diagnosis and Treatment of Severe Pit Viper Envenomation" — William J. Bailey, M.D., Naples.
- C "The Value of Radionuclide Brain Flow and Static Studies in the Determination of Cerebral Death in Children" — G. N. Sfakianakis, M.D., Florida Association of Nuclear Physicians, Miami.
- D "Operation Childsaver" — Kathryn J. Hahn, Occupant Restraint Coordinator, Bureau of Highway Safety, Tallahassee.
- E "Computer Controlled Hyperthermia Unit for Cancer Therapy" — Juan V. Fayos, M.D.; Charles F. Gottlieb, Ph.D.; Young H. Kim, M.D.; and Quirino Balzano, Ph.D., University of Miami School of Medicine, Miami.

F-G "Chemical Dependency — A Treatable Family Illness" — Ronald J. Catanzaro, M.D., Palm Beach Institute Foundation, West Palm Beach.

H "Creative Nutritional Support in Head and Neck Cancer Patients" — W. J. Goodwin Jr., M.D.; Jacob H. Goldberger, M.D.; and Ann Van Zelst, R.D., Florida Society of Otolaryngology — Head and Neck Surgery and University of Miami Department of Otolaryngology, Miami.

J "Temporary Pacemaker Wire Insertion: A Simple, Safe and Effective Technique" — Daniel G. Knauf, M.D.; James A. Alexander, M.D.; and James R. Edgerton, M.D., Gainesville.

K-L "Plastic Surgery Update" — Florida Society of Plastic and Reconstructive Surgery.

M "Public health Epidemiology and Community Involvement" — Ramona M. Medina, R.N., and Robert May, M.D., M.P.H., Pasco County Health Department, New Port Richey.

N "Craniofacial Surgery: The State of the Art at the Tampa Bay Craniofacial Center" — Mutaz B. Habal, M.D., and Jack E. Maniscalco, M.D., Tampa Bay Craniofacial Center and University Community Hospital, Tampa.

O "Pulsed Doppler Imaging for Patients with Ophthalmic Disorders" — William M. Blackshear, M.D.; W. Sanderson Grizzard, M.D.; and James A. Rush, M.D., Department of Ophthalmology, University of South Florida College of Medicine, Tampa.

P "A Prosthesis for Palliative Treatment of Carcinoma of Hepatic Bile Duct" — Paul H. Niloff, M.D., and Fred L. Simon, M.D., Lake Worth.

Q "Hemodynamics, Atrial Dysrhythmia, Pathology and Surgical Treatment of Mitral Valve Disease" — R. Vijayanager, M.D.; D. Bognolo, M.D.; P. Eckstein, M.D.; D. Jeffery, M.D.; S. Sbar, M.D.; P. Natarajan, M.D.; and E. Willard, M.D., Tampa.

R "Intra-arterial BCNU Therapy for the Treatment of Patients with Malignant Brain Tumor" — A. M. Bremer, M.D.; T. Q. Nguyen, M.D.; P. Duarte, M.D.; R. H. Miller, M.D.; M. Northup, M.D.; and R. Balsys, M.D., University Hospital of Jacksonville.

S "Tetralogy of Fallot" — Louis E. Cimino, M.D.; James G. Henry, M.D.; and Judith H. Martino, R.N., Department of Cardiology, All Children's Hospital, St. Petersburg.

T "Florida Association of Blood Banks" — Dorothy M. Hansen, Executive Director, Florida Association of Blood Banks, Orlando.

U "Asthma and Allergy Foundation of America — South Florida Chapter" — Marie Traub, President, Hollywood.

V "Nutritional Pitfalls in Medical Practice" — John O. Rao, M.D., and Rosemarie O'Shaughnessy, Ph.D., Kissimmee.

W "Myopia Surgery" — Albert C. Neumann, M.D., Deland.

Z, Y, Z, AA, BB, CC, DD, & EE
Programmed Instruction/Wyeth AutoTutors

- FF "To Your Health" — Duval County Medical Society.
- GG "Rheumatic Fever/Rheumatic Heart Disease Task Force" — Florida Heart Association.
- HH "Foreign Bodies in Pediatric Tracheobronchial Tree" — Farhat Moazam, M.D.; Frederick C. Ryckman, M.D.; John W. Robertson, M.D.; and James L. Talbert, M.D., University of Florida College of Medicine, Gainesville.
- JJ "Florida Medical Directors Association" — A. W. Browning Jr., M.D., Jacksonville.
- KK "International College of Surgeons" — Robert H. Hux, M.D., Regional Membership Chairman, Leesburg.

Foyer 1 "To Your Health" — Duval County Medical Society.

- 3:00 p.m. — First Session of House of Delegates —
4:00 p.m. **Mezzanine Theatre.** (Badges must be worn by delegates, and they are requested to be seated with their delegation by 2:55 p.m.)

Speaker: Mr. Roy Pfautch, President, Civic Services, Inc., St. Louis, Mo.

- 6:30 p.m. — President and President-Elect's Party
8:00 p.m. — **Art Show Area in Exhibit Hall.** (All delegates are invited to be present. Cash Bar. Balloting for your favorite entry.)

FRIDAY, MAY 7, 1982

Florida Medical Association Auxiliary, Inc.

54th Annual Meeting, May 5-May 8, 1982 Daily Schedule of Meetings and Activities

WEDNESDAY, MAY 5, 1982

- 10:00 a.m. — Registration for State Officers, Chairmen and County Presidents — **FMA General Registration, Inside Exhibit Hall.**

Pre-registration for House of Delegates — **FMA General Registration, Inside Exhibit Hall.**

- 2:00 p.m. — COLOR I — Color Consultation —
4:00 p.m. Lecture and Demonstration; everyone is invited; fee, \$3.00 — **Embassy Room East.**

THURSDAY, MAY 6, 1982

- 8:00 a.m. — Registration at FMA General Registration — **Inside Exhibit Hall.**
4:30 p.m.
9:00 a.m. — Hospitality Room — **Embassy Room East, Mezzanine.**
5:00 p.m.
10:30 a.m. — Pre-Convention Executive Committee Meeting for elected state officers — **President's Suite.**
12:00 Noon
1:00 p.m. — Pre-Convention Board of Directors
2:30 p.m. Meeting for State Officers, State Chairmen and County Presidents (Delegates and members are welcome as guests) — **Mezzanine Theatre.**

- 7:30 a.m. — Post-Convention FMA-A Executive Committee Meeting — **President's Suite.**

- 8:00 a.m. — Registration at FMA General Registration — **Inside Exhibit Hall.**
4:30 p.m.

- 9:00 a.m. — Hospitality Room — **Embassy Room East, Mezzanine** (will be closed 11:00 a.m. to 2:00 p.m.)
5:00 p.m.

- 8:25 a.m. Promptness Prize

- 8:30 a.m. — Second Session of House of Delegates
10:50 a.m. **Mezzanine Theatre.**

Speakers: Mrs. Torrence P.B. Payne, President-Elect, AMA-A, Newburgh, N.Y.

Mrs. Hazel Lewis, Executive Director, AMA-A, Chicago, Ill.

Reports of Committees

Election of Nominating Committee

Election of Delegates, AMA Auxiliary

Election of Officers, FMA Auxiliary

- 11:00 a.m. — FMA Baldwin Lecture — **Regency Room North.**
12:00 Noon

- 12:20 p.m. — AUXILIARY AWARDS LUNCHEON
1:30 p.m. — Art Show Awards, Editor's Award, AMA-ERF, Membership, International Health Awards, Peggy Wilcox Trophy; Past Presidents and County Presidents and Branch Chairmen honored — **Cafe Cristal.**

- 1:55 p.m. Promptness Prize

- 2:00 p.m. — Third Session of House of Delegates

3:30 p.m. — Mezzanine Theatre.

Presentation of County Activities

Greetings from FMA President —
Sanford A. Mullen, M.D.

Installation of Officers, 1982-1983.

SATURDAY, MAY 8, 1982

7:30 a.m. — Post-Convention FMAA Executive

8:30 a.m. Committee Meeting — **President's Suite.**

9:00 a.m. — Post-Convention Board of Directors

11:00 a.m. Meeting for all 1982-83 State Officers, Committee Chairmen, County Presidents and Branch Chairmen. County Officers and Committee Chairmen, members and guests are welcome. Mrs. Daniel B. Nunn, Jacksonville, 1982-83 President, presiding — **Embassy Room West.**

12:15 p.m. AUXILIARY/FLAMPAC LUNCHEON — **Les Ambassadeurs.**

Speaker: U.S. Sen. Paula Hawkins.

Errata

In an article entitled "Potassium Supplementation: Comparative Studies in Nonedematous and Edematous Patients" by Thomas J. Merimee, M.D., which was published in the January 1981 issue of *The Journal* (Vol. 68, No. 1), reference was made under "Study 1" on page 37 that "Each glass contained 100 ml of juice..." The author wishes to correct the measurement to read "8 oz."

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CARDIOVASCULAR PROBLEMS**
Tenth Annual Conference

At

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**May 30, May 31 (MEMORIAL DAY),
June 1st, 1982**

Guest Speakers: Charles Fisch, MD
Kenneth M. Rosen, MD
Samuel Sclarovsky, MD

**University of
Miami Faculty:** Agustin Castellanos, M.D.,
Bernard Fogel, M.D.,
Louis Lemberg, M.D., and
Robert J. Myerburg, M.D.

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American Academy of Otolaryngology and the American Council of Otolaryngology have added Head and Neck Surgery to their titles.

Diseases of the complex head, neck, ear, nose and throat region have always been very prevalent.

Since late in the 19th century, a group of physicians have focused their interest and care on this area of the body. In 1914 ophthalmologists founded the first national examining board. In 1925 physicians concentrating their practice on the ear, nose and throat area incorporated the American Board of Otolaryngology.

Combined meetings of these two societies developed educational and organizational concepts widely copied by both medical and commercial organizations. Ophthalmologists and otolaryngologists were the first to inaugurate continuing education with instruction courses. These specialty groups were the first to make board certification required for membership.

Otolaryngology — Head and Neck Surgery residencies have been four years in duration since 1959 and now an additional year has been added for all trainees starting in July 1981.

Otorhinolaryngology has evolved into a truly regional specialty treating all aspects of disease of the ear, nose, throat, head and neck region including plastic, reconstructive, traumatic, oncologic and cosmetic problems of the area. We welcome the new official name, "Otolaryngology — Head and Neck Surgery", as symbolic of the multiple medical-surgical capabilities available to our patients and medical colleagues.

John W. Stone, M.D.
Lakeland

Rep. Lehman on methaqualone

(Editor's Note: Since the time this letter was received, Senate Bill 100 — the companion bill to HB 156 — has been signed by Governor Bob Graham and will become law on July 1, 1982.)

To the Editor: Known in the black market as "ludes," the Methaqualone (Quaaludes — *Mequin) has accounted for 174 deaths in Dade County over the last ten years, the majority since 1978. Deaths are due to suicide, homicide, overdose, and auto accidents. The typical abusers is white, 25-35 years old, and frequently *polydrug users* (1 - use several drugs or 2 - use black market ludes containing drug contaminants). The drug modifies judgement and motor coordination, relaxes inhibitions, increases sexual desires and may produce a "high." This drug is sometimes used to counteract the effects of a cocaine high.

In 1979, the disciplinary sections of the Medical Practice Act were expanded. Two sections deal specifically with Schedule II controlled drugs which include Methaqualone:

1. "Employing a trick or scheme in the practice of medicine when such scheme or trick fails to conform to the generally prevailing standards of treatment in the medical community."

Example: "Stress Clinics"

Here, clients walk in, fill out a form, briefly see a doctor, pay \$100 cash, get a script for 40 quaaludes and are permitted to return in 30 days for another script and another \$100. (Street value — \$200-\$320).

2. "Prescribing or dispensing any controlled substance other than in the course of the physician's professional practice. It shall be legally presumed that prescribing or dispensing Schedule II controlled substances inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician's professional practice, without regard to his intent."

Example: "Script Doctors"

Physicians, osteopaths, dentists, podiatrists, and veterinarians who, in the course of their daily practice, write prescriptions for quaaludes inappropriately or in excessive amounts not indicated by any specific complaint or illness.

In the 1982 session, legislation has been introduced to reduce the over-prescribing of quaaludes:

1. HB 156 by Rep. Fred Lippman and Rep. David J. Lehman removes Methaqualone from Schedule II (*severely restricted medical use* in the United States) and places it in Schedule I (*no currently accepted medical use* in the United States) and further states that "and shall not be prescribed or dispensed by practitioners or dispensed by pharmacists."
2. A bill by Rep. David J. Lehman that will close two loop-holes in the law:
 - a. Assist the investigators of the Department of Professional Regulation to obtain patient records *without a written release*. (no patient on quaaludes is going to cut off his source of this drug by giving written consent to have his medical records released by his health care practitioner.
 - b. Expressly delineate the Department's power to *inspect pharmacies* and to *seize evidence* in order to establish violations of health care related practice acts.

Methaqualone is the most serious drug problem that we have in Florida today. The potential of abuse of this drug which causes the death and injury of so many young people far exceeds any legitimate medical indication for the drug.

Rep. David J. Lehman, M.D.
State Representative
97th District
Hollywood

*Present trade name product by Lemmon Pharmaceuticals
("Lemmon 714" stamped on tablets)



ETC.

Restaurants of the gold coast

Editor's Note: "Where's a good place to eat?" will be a frequently asked question when physicians convene for the 108th Annual Meeting of the Florida Medical Association in Hollywood in May. Dr. Charles A. Monnin Jr., is a man with the answers. Dr. Monnin is a connoisseur par excellence, with such distinguished credentials as: Chevalier Ordre Du Merite Agricole, French; Commandarie De Bordeau, France; Bailli of Miami Chapter of Confrerie de la Chaine des Rottisseurs; Judge in Budapest of Culinaire Arts with Chaine des Rotisseurs, 1968; Member, International Wine and Food Society; and Member, Miami Chapter, Sommelier Guild.

Professionally, Dr. Monnin is a Clinical Associate Professor of Surgery at the University of Miami School of Medicine, a Diplomat of the American Board of Surgery, and a Fellow of the American College of Surgeons. The Journal asked Dr. Monnin to prepare a restaurant guide for physicians attending the Annual Meeting. Here is his report.

The FMA convention at the Diplomat Hotel in Hollywood places us in the heart of some of the finest eateries and feederies in America — certainly better than one would find in Chicago, Los Angeles and many of the other great cities, in my opinion. Coral Gables and South Miami have been blessed with an excellent concentration of fine restaurants, but they are not listed here because of the distance.

I also will not mention Joe's Stone Crab Restaurant at the extreme end of Miami Beach. However, stone crabs are available in most of the better restaurants. Listed below are but a few of the hundreds of restaurants on our Gold Coast. An indication of price

is provided, but this can vary depending on the "extras" being ordered. *Reservations are suggested for all.*

The first three restaurants listed are owned and operated by the Picot family and have received almost all of the culinary awards possible.

Casa Vecchia

209 North Birch Road
Fort Lauderdale
463-7575

Excellent Italian. Overlooks the intracoastal waterway. Expensive.

La Vieille Maison

770 East Palmetto Park Road
Boca Raton
391-6701

A little drive, all expressway. Well worth it! Superb food. Antique "Old House" decor. Open daily. Expensive.

The Down Under

3000 East Oakland Park Boulevard
Fort Lauderdale
563-4123

Very popular. Very good. American and European dishes. Expensive.

Les Trois Mousquetaires

2447 East Sunrise Boulevard
Fort Lauderdale
564-7513

An intimate restaurant with French haute cuisine. Expensive.

Il Giardino's

609 East Las Olas Boulevard
Fort Lauderdale
763-3733

Well prepared Italian dishes with paddle fans overhead, thriving greenery with a soft, quiet mood.

Mai-Kai

3599 North Federal Highway
Fort Lauderdale
563-3272

One of the nation's top purveyors of Polynesian-type food — the type that made Trader Vic's famous. Nightly review of beautiful sarong-clad girls and knife-throwing strong men. Moderate.

Portage

1717 Eisenhower Boulevard
(Just off 17th Street Causeway)
Fort Lauderdale
467-6600

Continental restaurant, exquisite cuisine and quiet elegance. Overseen by Peter Scheuerl.

The French Quarter

Cafe de Paris

Las Olas and Southeast 8th Avenue
Fort Lauderdale
463-8000 467-2099

Both open for lunch, dinner, supper. Dancing upstairs. The owner, Louis Flemati, a Swiss, is always on the scene, having developed these two magnificently landscaped restorations with their French, New Orleans menu. They are among the most distinctive restaurants in Fort Lauderdale. Expensive.

Pier 66

2301 Southeast 17th Street Causeway
Fort Lauderdale
524-0566

A sky-scraping pause with a view of one of the world's great marinas. The elevator takes 66 seconds; the floor rotates every 66 minutes. An excellent place to begin an evening of dining. No food. Great for cocktails.

Yesterdays

3001 East Oakland Park Boulevard
Fort Lauderdale
561-4400

Lovely atmosphere. Good food. Moderately expensive. The Plum Room on top is interesting. Expensive.

Forge Restaurant

432 Arthur Godfrey Road
Miami Beach
538-8533

Open until 2 a.m. Decorated with art treasures. Large wine cellar. Very good. Expensive.

Cafe Chaveron

9561 East Bay Harbor Drive
Bay Harbor
866-8779

Holiday Award for fine dining. Expensive.

Post and Paddock Restaurant, L'Hostellerie d'Argenteuil

9650 East Bay Harbor Drive
Miami Beach
866-8706

Very popular locally. Horsey decor. Lunch and dinner. Expensive.

Paesano

1301 East Las Olas Boulevard
Fort Lauderdale
467-3266

Popular Italian cuisine, good wine selection, friendly atmosphere, moderately priced.

Tark's (3 locations)

1317 South Federal Hwy., Dania Tel. 925-TARK
Route 441 and Peters Rd., Plantation, Tel. 792-TARK
4300 Hollywood Blvd., Hollywood, Tel. 962-CLAM

Raw Bar. Very modest, bar type surroundings with tremendous turnover of clams, oysters, chicken wings, assuring excellent fresh quality. One of Dr. Joe Davis' (Past President) favorites. No coats and ties. Moderate.

Chuck's Steak House (2 locations)

1201 Southeast 17th Street Causeway, Ft. Lauderdale,
527-4400

300 South State Road #7, Plantation, 584-8817.

No reservations. Known for its steaks and prime rib. Excellent salad bar. A real bargain. (About \$12.00) Moderate.

Cafe September

2975 North Federal Highway
Fort Lauderdale
563-4331

Novelle cuisine, excellent wines, and elegant decor with the beautiful people. Adjoins the September nightclub. Expensive. (The Chef is Ulrich, ex of Club 41; the Pastry Chef is late of Four Seasons in New York.)

Le Parisien French Restaurant

474 Arthur Godfrey Road
Miami Beach
534-2770

Miami Beach's premier French restaurant, with the owner doing the cooking and living up to the establishment's award-winning traditions. Moderately expensive.

Umberto's

308 North Federal Highway
Hallandale
456-2110

Nepenthe

3937 North Federal Highway
Fort Lauderdale
564-8466

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Many thanks to Yolanda Maurer, Editor and Publisher of *The Best of Broward*, and Glen Parker, a fellow Bailli, for their assistance and advice.

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*Reference: 1981/82 American Druggist Blue Book

1/82

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SU-TON[®]

Liquid Tonic

A Tonic for Geriatric Patients

A pleasant tasting tonic containing iron, vitamins, minerals, and an analeptic. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

DESCRIPTION Forty-five milliliters of SU-TON contains the following ingredients: Pentylenetetrazol 30 mg • Niacin, 50 mg • Vitamin B-1, 10 mg • Vitamin B-2, 5 mg • Vitamin B-6, 1 mg • Vitamin B-12, 3 mcg • Manganese (as Manganese Sulfate), 1 mg • Magnesium (as Magnesium Sulfate), 2 mg • Zinc (as Zinc Sulfate), 1 mg • Iron (as Ferric Pyrophosphate, Soluble), 22 mg • Alcohol, 18%

INDICATIONS AND USAGE SU-TON contains pentylenetetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

CONTRAINDICATIONS Epilepsy, convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

ADVERSE REACTIONS Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE Drug dependence has not been reported with SU-TON.

OVERDOSAGE Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage. Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION One tablespoonful (15 ml) 3 times a day 20-30 minutes before meals. This drug is not for use in children under 12 years of age.

HOW SUPPLIED Bottles of 473 ml (16 fl. oz.)

Federal law prohibits dispensing without prescription.

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(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.

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Clinical efficacy may not always correlate with blood levels.

†Due to susceptible organisms.

3. Data on file. Wyeth Laboratories.
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See important information on adjoining page.

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Cyclapen®-W (cyclacillin) produces twice the peak serum concentration* (15.6 mcg/ml versus 7.3 mcg/ml) in half the time (30 minutes versus 60 minutes).¹

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†Due to susceptible organisms

1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC. Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981

2. Multicenter trials. Data to be published

See important information on page after next

Cyclapen®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of the therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age. Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Branchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.

†depending on severity.

How Supplied Tablets 250 mg and 500 mg in bottles of 100. Oral Suspension 125 mg and 250 mg per 5 ml in bottles to make 100 ml and 200 ml of Suspension.

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patients. The older patient may have some disorder or socioeconomic problem that can undermine good nutrition.²

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Indications: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.

Contraindications: Hypersensitivity to any component

Warnings: Not for pernicious anemia or other megaloblastic anemias where vitamin B₁₂ is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B₁₂ deficiency who receive supplemental folic acid and who are inade-

quately treated with B₁₂.

Precautions: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

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5,000,000 hospital patients with infections.⁴ Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.³

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References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease*, op. cit., p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, op. cit., pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med* 89 (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

Dosage and Administration: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.

How Supplied: Golden yellow, capsule-shaped tablets—bottles of 100.

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THE MULTIVITAMIN/MINERAL FORMULATION

Lifelong sexual vigor: how to avoid and overcome impotence

By Marvin B. Brooks, M.D., 249 Pages. Price \$12.95. Doubleday and Company, Inc., New York, 1981.

Coitus, copulation or sexual commerce, "transcending all other experiences and the ultimate in human sharing" unfortunately, no longer exists for millions of couples. The reason, *impotence*, is discussed in an interesting book of just over 200 pages. Written about and for the male, it could be of interest to all men and the women who love them and who "savor the magic of sexual intercourse and cherish the warmth and affection that go hand and hand with it." Written by a urologist and his wife, it contradicts such myths as "use it or lose it", "impotence is normal, natural and inevitable", "a natural consequence of aging" and "it is abnormal or immoral for older people to continue sexual activity."

A description of the anatomy of male reproductive systems includes the brain and the hypothalamus. Although the brain plays an important role in aiding the male to get ready for intercourse, this chapter denotes that he cannot do so by exercising his mind or concentration alone for the act is a completely reflex response to appropriate stimuli. Conversely, the cerebral cortex can be very much involved in inhibiting the male's performance, the situation known as psychogenic impotence.

Written, apparently, for the laity to understand, it is informative as well as reassuring to the medical practitioner who, when questioned by his impotent patient, might recommend a perusal of this book.

Medications, alcohol, operations and psychogenic causes of impotence are discussed. Condemning aphrodisiacs, sexual aids, prostitutes or surrogate partners, a comprehensive section outlines modern sex therapy and how to find help with methods of performing a do-it-yourself diagnosis and treatment. A list of clinics providing such services is included, surprisingly, none being in Florida.

The final chapter entitled "The Woman's Role in Impotence" compares breast augmentation, mam-

moplasty and penile implants, external things on which a strong relationship need not depend for "there is more to love than sexual organs".

Not intended to be a comprehensive clinical guide to human sexuality; nevertheless, it would be a valuable addition to any physician's library.

C.M.C.

Clinical pediatric dermatology

By Sidney Hurwitz. 481 Pages. Price \$75.00. WB Saunders Co., Philadelphia, 1981.

The scene is an examining room in a physician's office. After a routine check up, a two-year-old child and his mother are ready to go. The doctor has said good-bye and is leaving the room. *Mother*: "Just a moment doctor, I forgot to show you some peculiar spots on John's back. I'll undress him; it won't take a minute." She proceeds to do so. "Here they are right by the spinal bone." *Doctor*: "Where? I don't see anything." *Mother*: "Right there. See those red spots?" *Doctor*: "Oh yes, those are mother spots." *Mother*: "Mother spots! What are mother spots?" *Doctor*: "Mother spots are spots no one would notice except a mother."

Physicians who care for children experience something of the sort almost daily. The author of this book states that 20 to 30 percent of children seen in the medical setting have problems directly related to the skin.

This book is one of the significant pediatric books to appear in the last decade. While not encyclopedic, it covers in 19 chapters and in a practical way nearly all skin conditions that the practitioner will encounter among children. As is proper, conditions more commonly seen in childhood such as the common contagious diseases, atopic eczema and such "new" diseases as the muco-cutaneous lymph node syndrome (Kawasaki's Disease) are stressed. There are over 1,000 references arranged at the end of the chapters.

Besides being well organized and skillfully written the book becomes a valuable asset for office, clinic or hospital practice because of numerous colored illustrations. Although the author indicated that he received financial aid in presenting the color work, this invaluable feature probably accounts for the high cost of the book.

During many years in pediatric practice, I have referred to dermatology books more than to any others, excepting the classic generalized textbooks. This is usually to help in recall of treatment or to show patients illustrations of disease which may help avoid impatience as a chronic condition persists. While the book is valuable for these uses it is especially strong in treatment, as the author recognizes that there are often many ways to manage skin conditions and, moreover, he usually gives the trade name as well as the generic designation of agents used in treatment.

Through the years I have asked authorities who lecture on skin problems in children, including perhaps a score holding pediatric dermatology round tables at meetings of the American Academy of Pediatrics, to recommend a book in the field. Almost invariably they refuse to do so. This book will probably be acceptable. It is recommended as a tool for all physicians who give medical care to children.

Hugh A. Carithers, M.D.

- Dr. Carithers is a practicing pediatrician in Jacksonville.

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Each Tablet Contains:

Pentylenetetrazol...	25.0 mg
Pheniramine maleate...	12.5 mg
Nicotinic acid...	50.0 mg

Clinically proven actions

- Antihistaminic
- Cerebral stimulant
- Vasodilator

Few side effects

- Vasodilation occasionally causes facial flushing which can be minimized by recommending that Ru-Vert[®] be taken following meals or with food.

Dosage

- One or two tablets three times a day

Please see next page for a summary of prescribing information

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In Vertigo On Balance... **RU-VERT®**

See following prescribing information.

DESCRIPTION: Each tablet contains the following active ingredients:

Pentylene-tetrazol	25.0 mg
Pheniramine maleate	12.5 mg
Nicotinic acid	50.0 mg

INDICATIONS: Ru-Vert is indicated as an adjunct therapy in the symptomatic treatment of acute or chronic vertigo.

CONTRAINDICATIONS: Convulsive disorders or, known history of sensitivity to any of the listed active ingredients. Because of the vasodilating action of nicotinic acid, Ru-Vert should not be used in patients with hypotension.

WARNINGS: The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindications to pentylene-tetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of Ru-Vert who have heart disease. While pentylene-tetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

Pheniramine maleate, like other antihistamines, may produce sedative side effects in certain patients.

Transient vasodilatation due to rapid absorption of nicotinic acid may produce facial flushing and a sensation of warmth. These effects may be ameliorated by recommending that Ru-Vert be taken following meals or with food.

ADVERSE REACTIONS: Pentylene-tetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylene-tetrazol.

DRUG ABUSE: Drug dependence has not been reported with Ru-Vert.

OVERDOSAGE: Signs and symptoms of acute overdose may be due primarily from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DDSAE AND ADMINISTRATION: The recommended dosage of Ru-Vert for vertigo or motion sickness is 1 or 2 tablets three times a day with meals or light snacks.

This drug is not for use in children under 12 years of age.

HOW SUPPLIED:

Bottles of 100 tablets

Bottles of 300 tablets

Federal law prohibits dispensing without prescription.

NDC 0524-0060-01

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sensation after taking a higher
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ondary reaction some will com-
plain of nausea, sweating and ab-

dominal cramps. The reaction is
usually transient.

INDICATIONS: As a cerebral
stimulant and vasodilator.

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DOSAGE:** One capsule three
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WARNING: Overdosage may
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CONTRAINDICATIONS: Epilepsy
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Third Annual Advanced Cardiac Life Support for Physicians, May 7-8, Cedars of Lebanon Health Care Center, Miami. For information: Debbie Zayas, 1400 N.W. 12th Ave., Miami 33136.

Family Practice Section — Florida Medical Association Meeting, May 8, Hollywood by-the-Sea. For information: Bernard Breiter, M.D., P.O. Box 1990, Daytona Beach 32015.

Advances in Neonatal and Pediatric Respiratory Care — 8th Annual Seminar, May 16-19, Clearwater. For information: Barbara Anthony, ACH 801 6th St., St. Petersburg.

Master Approach for Cardiovascular Problems, May 29-June 1, Walt Disney World, Fla. For information: Louis Lemberg, M.D., Dept. of Cardiology, University of Miami School of Medicine, Box 016960, Miami 33101.

JUNE

Cardiology for the Practitioner, June 4-11, Mississippi Queen Steamboat Cruise. For information: Lamar Crevasse, M.D., University of Florida College of Medicine, Box J-233, Gainesville 32610.

33rd Annual Scientific Assembly, June 9-13, Fernandina Beach. For information: Guy T. Selander, M.D., 4057 Carmichael Ave., #229, Jacksonville 32207.

Annual Homecoming in Psychiatry, June 11-12, Miami. For information: University of Miami, Dept. of Psychiatry, P.O. Box 016960, Miami 33101.

Tumor Board Meeting, June 18, Pompano Beach. For information: Steven Valenstein, M.D., 941-0993.

18th Annual Resident's Day in Ophthalmology, June 19-21, Key Biscayne. For information: Gaby Kressly, Dept. of Ophthalmology, University of Miami, P.O. Box 016960, Miami 33101.

Conference on Reyes Syndrome, June 25, USF College of Medicine, Tampa. For information: R. Fernandez, M.D., 12901 N. 30th St., Box 15, Tampa 33512.

JULY

Curso de Medicina Ocupacional (in Spanish) July 12-16, Miami. For information: Rafael Penalver, M.D., Dept. of Office of International Medical Education, P.O. Box 016960, Miami 33101.

SEPTEMBER

Tips, Tricks, Traps and Techniques, Recent Developments in Family Practice, Sept. 9-12, St. Augustine. For information: James R. Biggerstaff, M.D., 1406 Kingsley Ave., Orange Park 32073.

Polk County Medical Association 1982 Dinner Meeting Programs, Sept. 8, Lakeland. For information: Eugene L. Nagel, M.D., P.O. Box 927, Lakeland 33802.

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Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid 100 mg.
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Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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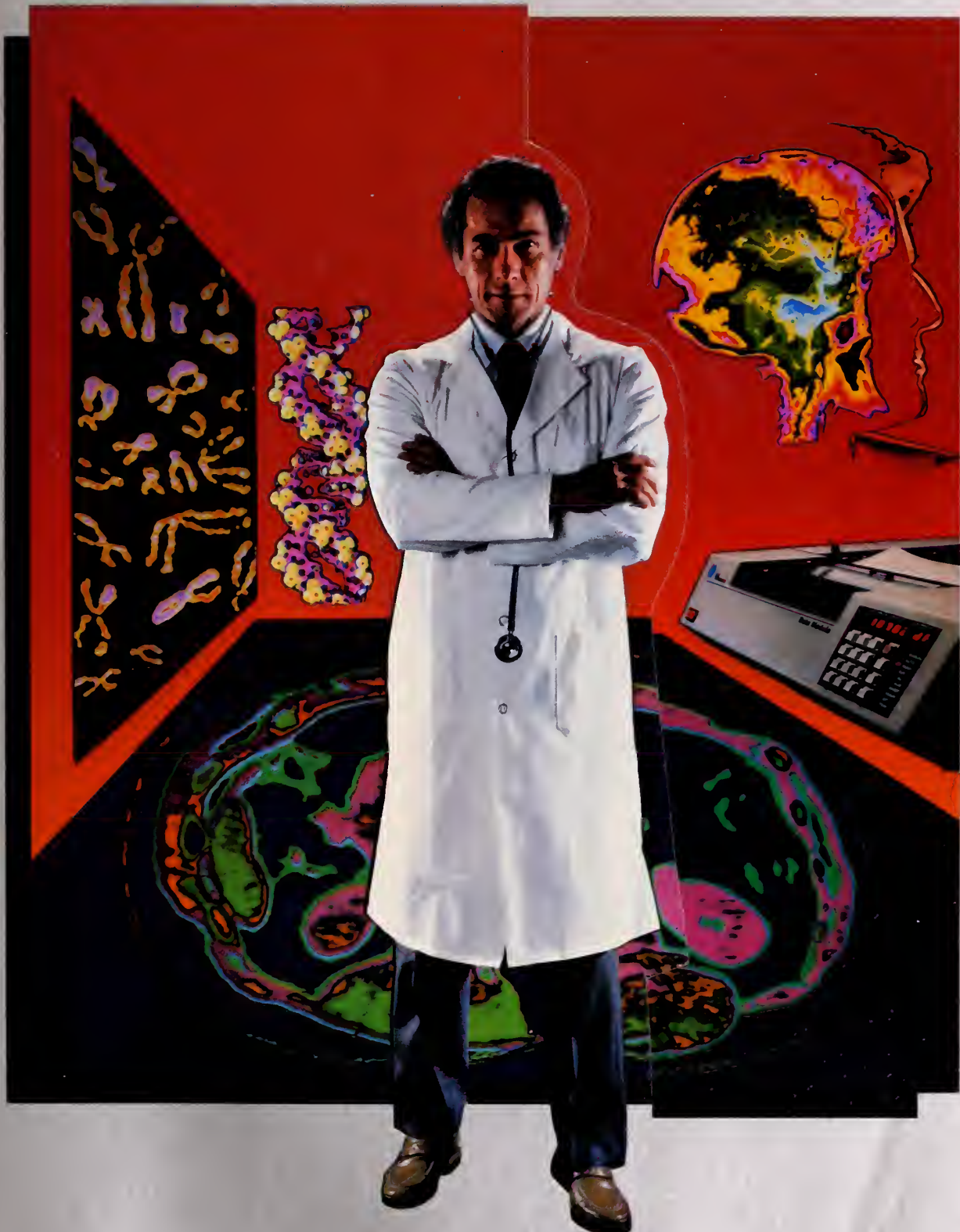
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An Agent of Change...



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Ativan®: Agent of Change

(lorazepam)

Your patients are changing

the population is getting older, more people are holding a second job, patients are more concerned about the medications they take

Medical knowledge is changing

there are diagnostic resources and surgical techniques undreamed of only a few years ago, biomedical engineering, new insights also into the action of drugs.

In this changing environment, the way you are practicing medicine is changing too...

Twenty years ago, the benzodiazepines represented a real step forward in the management of anxiety and tension states. In recent years, however, concern about drug accumulation and clearance has led physicians to re-evaluate their use of these agents. In light of current knowledge, many clinicians are changing from multi-metabolite benzodiazepines to Ativan® (lorazepam)—a metabolically and pharmacokinetically distinctive agent that offers clinical advantages which more closely meet the expectations of a modern anxiolytic.



because...

it's shorter acting, with less accumulation*

In contrast to long-acting benzodiazepines, Ativan has a short, 12-hour half-life, and no active metabolites. In multiple-dose therapy, Ativan accumulates for only two to three days before reaching steady state; the long-acting benzodiazepines—diazepam CIV, chlorthalidone CIV, clonazepam CIV and prazepam CIV—with their active metabolites—accumulate for as long as 20 days, increasing the likelihood of excessive sedation.

it doesn't interact with drugs metabolized by P450 microsomal enzymes

Most benzodiazepines undergo oxidative metabolism and thus utilize the hepatic microsomal enzyme system. Ativan®, however, is metabolized by glucuronidation and does not compete with other drugs for cytochrome P450. Thus, when Ativan is given with Tagamet® (cimetidine), for example, clearance is not delayed, nor sedation increased*—unlike reported observations with patients on other benzodiazepines.^{1,5}

it gives you greater control of therapy

The short half-life of Ativan® facilitates more rapid response to dosage adjustments, allowing you to titrate therapy to patients' changing needs. Also, once you decide to discontinue Ativan, it will be out of your patient's system four days after the final dose—in contrast to long-acting benzodiazepines and their active metabolites which take as long as two weeks to be totally eliminated.

Ativan®
for (lorazepam)@
Anxiety

See important information on following page

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3. Palwardhan RV, Yarborough GW, Desmond PV, et al. Gastroenterology 79:912-916, 1980.
4. Sellers EM, Naranjo CA, Peachey JE. N Engl J Med 305:1255-1262, 1981.
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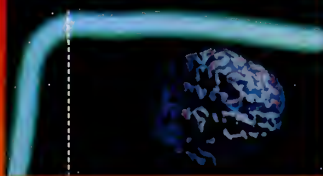
*Pharmacokinetics cannot as yet be directly related to efficacy.

†All benzodiazepines produce additive effects when given with CNS depressants such as barbiturates or alcohol.

Ativan®: Agent of Change

(lorazepam) 

Ativan: Accumulation to steady state extends for only 2-3 days
No active metabolites



Day 3 depiction of typical blood level



- Little accumulation lessens likelihood of excessive sedation
- Unlike most benzodiazepines, Ativan does not compete with other drugs, such as Tagamet® (cimetidine), for the microsomal enzyme system during biotransformation
- Metabolism not affected by age or liver dysfunction
- Short half-life provides greater control of therapy
- Promptly eliminated from patient's system after discontinuation
- Specifically evaluated and found effective for anxiety associated with cardiovascular and gastrointestinal disorders
- A distinctive change from long-acting benzodiazepines, all of which have active metabolites and are much the same

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any anxiolytic agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and micropthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Dosage: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

How Supplied: 0.5, 1.0 and 2.0mg tablets.

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**THE PATIENT THINKS
HE HAS HEART TROUBLE...**





...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

VALIUM[®] ^{IV}

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

**BECAUSE YOU'RE CONVINCED
THE PATIENT NEEDS IT**



Please see summary of product information on the following page.

VALIUM® (diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy). The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

How Supplied: For oral administration, Valium scored tablets—2 mg, white, 5 mg, yellow, 10 mg, blue—bottles of 100* and 500,* Prescription Paks of 50, available in trays of 10,* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

*Supplied by Roche Products Inc., Manati, Puerto Rico 00701

†Supplied by Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110



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MAY 1982 Vol. 69, No. 5

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COVER

The cover this month features a painting by Tallahassee artist Jean Henriksen, noted for her paintings of Florida's wilderness areas. *The Journal* is grateful to Ms. Henriksen for allowing us to use her painting of Wakulla Springs, located south of Tallahassee, on our May cover.

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Nicotinic acid. 50.0 mg

Clinically proven actions

- Antihistaminic
- Cerebral stimulant
- Vasodilator

Few side effects

- Vasodilation occasionally causes facial flushing which can be minimized by recommending that Ru-Vert[®] be taken following meals or with food.

Dosage

- One or two tablets three times a day

Please see next page for a summary of prescribing information

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In Vertigo On Balance... RU-VERT®

See following prescribing information.

DESCRIPTION: Each tablet contains the following active ingredients:

Pentylentetrazolol	25.0 mg
Pheniramine maleate	12.5 mg
Nicotinic acid	500.0 mg

INDICATIONS: Ru-Vert is indicated as an adjunct therapy in the symptomatic treatment of acute or chronic vertigo.

CONTRAINDICATIONS: Convulsive disorders or known history of sensitivity to any of the listed active ingredients. Because of the vasodilating action of nicotinic acid, Ru-Vert should not be used in patients with hypotension.

WARNINGS: The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindications to pentylentetrazolol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of Ru-Vert who have heart disease. While pentylentetrazolol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

Pheniramine maleate, like other antihistamines, may produce sedative side effects in certain patients.

Transient vasodilatation due to rapid absorption of nicotinic acid may produce facial flushing and a sensation of warmth. These effects may be ameliorated by recommending that Ru-Vert be taken following meals or with food.

ADVERSE REACTIONS: Pentylentetrazolol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylentetrazolol.

DRUG ABUSE: Drug dependence has not been reported with Ru-Vert.

OVERDOSAGE: Signs and symptoms of acute overdose may be due primarily from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION: The recommended dosage of Ru-Vert for vertigo or motion sickness is 1 or 2 tablets three times a day with meals or light snacks.

This drug is not for use in children under 12 years of age.

HOW SUPPLIED:

Bottles of 100 tablets

Bottles of 300 tablets

Federal law prohibits dispensing without prescription.

NDC 0524-0060-01

NDC 0524-0060-03

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Indications

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RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Branchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*), *H. influenzae*, and Group A beta-hemolytic streptococci

Acute exacerbation of chronic bronchitis caused by *H. influenzae*

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacterio. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg t.i.d. body weight > 20 kg (44 lbs) 250 mg t.i.d.
Branchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day t.i.d.†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day‡
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.

†depending on severity

How Supplied Tablets 250 mg and 500 mg in bottles of 100. Oral Suspension 125 mg and 250 mg per 5 ml in bottles to make 100 ml and 200 ml of Suspension.

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and strep
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in children

*Rapidly excreted unchanged in urine.
Clinical efficacy may not always correlate with blood levels.

†Due to susceptible organisms

1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC. Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.

2. Multicenter trials. Data to be published.

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See important information on adjoining column.

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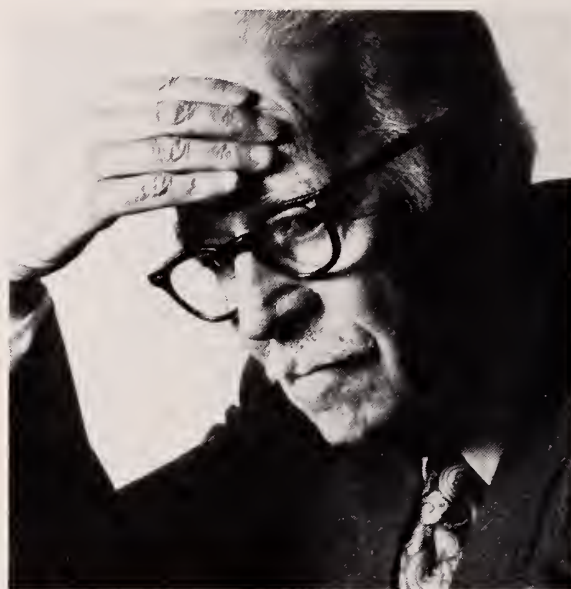
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Controlled sustained release of ISO-BID's isosorbide dinitrate through micro-dialysis diffusion can help reduce frequency and intensity of anginal attacks. This in turn can minimize patient's fear of attacks, and dependence on nitroglycerin.

Unlike ordinary sustained release products, ISO-BID releases isosorbide dinitrate at a smooth, continuous, predictable, controlled rate to provide for up to 12 hours of therapeutic activity. Micro-dialysis is dependent only upon the presence of fluid in the G. I. tract and not on pH or other variables. ISO-BID is particularly advantageous in the prevention of nocturnal angina.

DOSAGE: One ISO-BID capsule every 12 hours on an empty stomach according to need, for continuous 24-hour therapy. Some patients may require higher dosage levels. In these patients, dosage should be titrated, and they may require two ISO-BID capsules b.i.d. Not intended for sublingual use. Consult product brochure before prescribing.

THERAPEUTIC FOOTNOTE: IN TREATING ANGINA ... FAILURES MAY RESULT FROM INADEQUATE DOSAGE. Reports in the literature indicate the usefulness of higher dosage levels of isosorbide dinitrate.¹⁻³

INDICATIONS: Based on a review of this drug by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: For the relief of angina pectoris (pain of coronary artery disease). ISO-BID is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris. Final classification of the less-than-effective indication requires further investigation.

CONTRAINDICATION: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Use with caution in patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness

and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.

SAMPLES AND LITERATURE AVAILABLE.

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1. Shane, S.J.: Canadian Family Physician. November 1973.
2. Lemberg, L.: Practical Cardiology. February 1976.
3. Abrams, J.: New England Journal of Medicine. May 29, 1980.





Final comment

"Forsan et haec olim meminisse iuvabit."

Virgil

It is with mixed feelings that I approach the task of preparing my last President's Page for publication in *The Journal of the Florida Medical Association*. My feelings are mixed because the period of time in office twelve months, had passed so rapidly that many of the projects I had wanted to carry out during the year have not been fully accomplished. At the same time I fully agree that a one-year term for the President of the FMA is appropriate and desirable for many reasons. My concern about having not accomplished many of the things I had hoped to carry out are lessened by my contacts with previous presidents of the FMA who expressed similar concerns. This knowledge is very comforting to me as I approach the last days of my term in office.

Before beginning this final comment, I would like to take this opportunity to express publicly to my wife, Minnie, my appreciation for her support during my year as President of the Florida Medical Association. As she has consistently done throughout the 36 years of our marriage, Minnie has once again provided the stabilizing influence that has been so vital to me and our three sons. Without her help in this busiest year of my career, it would have been impossible for me to serve as President. Words to express my thanks to Minnie are completely inadequate, so I'll say simply, "Thank you."

Successor Praised • At the outset I would like to emphasize the fact that I have only the highest of praise for my successor, Dr. Robert E. Windom of Sarasota. I have had the privilege of working closely with Bob during the past year and I am confident that his year at the helm of the FMA will be the best year the organization has ever experienced. I am certain that Bob joins me in the anticipation that his successor's year will be even better.

One of the emblems of authority given me during the past year is a beautiful bronze plaque on which my



name has been inscribed as President for this current year. In addition the names of the 104 preceding presidents are listed. Many of the more recent presidents I have had the privilege of knowing personally. The names of the presidents from the more distant past are known to me only by reading about them and hearing about them. It is indeed an honor to have my name added to this long list of physician leaders which began in 1874 with the name of Abel S. Baldwin, M.D., our founding President.

The privilege of serving as President of the FMA is certainly the greatest honor that has ever been accorded me. I would like to take this opportunity to thank the members of the House of Delegates who elected me to this position and all of the individuals who supported my campaign when I was running for this office. These individuals have provided me with an experience that I shall cherish for the rest of my life.

As anyone who has been involved in the leadership of the FMA is well aware, the progress and achievements of the FMA are not those of a single individual serving as President. The President would be virtually completely ineffective if he did not have many interested and dedicated individuals who have brought their vast skills and energies to the FMA. These individuals include those who have served as officers and members of the Board of Governors as well as all council and committee chairmen and members. Countless volunteer hours have been devoted by these individuals to the good deeds of the Florida Medical Association. Added to these are the many individual physician members who provide leadership to the 45 county medical societies and 38 specialty organizations throughout this great state. And of course every competent medical practitioner member brings credit to the FMA by his or her practice of medicine.

In Praise of Our Staff • It is well understood that the actions of the doctor leaders of the state and county medical organizations of Florida are assisted in carrying out the responsibilities by an extremely able staff in the FMA office and in the county medical society and specialty groups which are large enough to have an administrative staff.

I would be remiss if I did not take this moment to single out Donald C. Jones, Executive Director of the FMA, who has recently been promoted to the position of Chief Executive Officer of the FMA. Throughout my year as president Don has been a travelling companion throughout the State and has given untiringly of his energies and talent to make my job much easier.

Our Executive Vice President, W. Harold Parham, D.H.A., has been consistently supportive and has always been ready to lend his assistance the entire year. John E. Thrasher, our Legal Counsel, and Donald S. (Scotty) Fraser, our Associate Executive Director and Executive Director of FLAMPAC, have been consistently helpful. Philip H. Gilbert, Edward D. Hagan, Robert J. Harvey and James F. McCloy have provided much able assistance during the year. The fine talents of the secretarial staff in the Association office, particularly Bonnie Taft and Judi Nolan, have been outstanding.

I would also like to take this opportunity to thank Kathryn W. Smith, my administrative assistant at the Jacksonville Blood Bank, who has done so much on a day to day basis in supporting my responsibilities as President. The staff directors of our four FMA field offices, Eugene H. Johnson in Miami, D. Craig (Chip) Collins in Tampa, Douglas M. Guetzloe in Orlando and George S. Palmer Jr., in Tallahassee have been particularly helpful. Space does not permit my being able to thank the many other talented members of the FMA staff for their support during the past year.

Thanks are also extended to the members of my personal pathology laboratory staff who have worked frequently at odd hours in order to help me maintain my schedule. Gay Baker, Penny Jones, Jennifer Kennedy, Kathy Heaton, Shannon Lewis, Nancy Purdy, Wendy Thompkins, Mimi Underwood, Faye Wilkinson and Shirley Windham are due many thanks. My most grateful appreciation is given to C. Merrill Whorton, M.D., my professional colleague, who has always been available to cover my practice when FMA duties called me away from professional practice and other responsibilities.

County Society Visits • During the past year I have had the privilege of visiting with medical societies and specialty groups throughout the State from Key West to Pensacola. I have been received cordially without exception by all of these groups. Many questions have come my way relative to the concerns of the practicing physician in Florida. Many times I have not known how to reply but throughout this learning experience I have tried to find the answers to the questions being asked.

One particular highlight of my year was the opportunity to visit each of the three medical schools in Florida. Having the opportunity to meet with the deans, faculty members, administrative staff and students was a most rewarding experience. Medical education has changed greatly, and for the better, since I was a medical student. The quality of the medical students is superb. It is comforting to know that the FMA has the prospect of leadership in the years ahead from this outstanding group of young men and women.

Throughout my visits around the state I have been consistently aware of the high quality of medical care which is rendered to the people of Florida.

I can think of no part of the State where the people do not receive this outstanding medical care. The efforts of the FMA and other medical organizations in working to assure continuing updating of physicians is paying vast dividends for the people of Florida. Similar activities in the other states provide untold benefits for the people of our entire country. Doctors have always been the key to the improvement of medical standards and continue to do an excellent job in this regard. In their role as advocates for the quality of care afforded their patients, doctors continue to provide outstanding stewardship of their trust and responsibility.

Maintaining Responsibility • There is no doubt that the medical profession in Florida is maintaining its responsibility for constant improvement in the quality of medical practice in the fashion that Dr. Abel S. Baldwin must have envisioned over a century ago. The group of six doctors who founded the FMA in 1874 would surely be proud of the 14,000-member organization now providing so much service to the State of Florida.

There are many challenges ahead for the Florida Medical Association and all of organized medicine. Medical doctors must be ever vigilant to the dangers of intrusion of the practice of medicine by those who are unqualified and who seek to become medical practitioners by legislative fiat rather than by pursuing a legitimate course of study in medical school and residency training programs. Because of this constant threat doctors can never relax their efforts to maintain adequate representation in the legislative halls and in the political arena. Support of FLAMPAC is a must by all physicians and their families throughout the State. Doctors must find allies who recognize the dangers to the people if the practice of medicine is fragmented among unqualified practitioners. It is only because the medical profession has taken the lead in scientific medicine during the past century that the people of the United States have received the high level of medical care now largely taken for granted.

Conclusion • As I come to the conclusion of my final President's Page, I wish that each and every member of the Florida Medical Association could be given the opportunity to serve as President of this magnificent organization. I am confident that the skills and dedication of the members of the FMA will assure the highest level of quality medical care to the people of Florida. It is no exaggeration to say that everyone in Florida will forever be indebted to Dr. Abel S. Baldwin and his colleagues for establishing the Florida Medical Association.

Sanford A. Pullen, M.D.



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Cutlass/Regal	247.00 per month	Mercedes, 240 Diesel	424.61 per month
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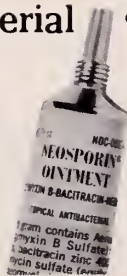
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INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyoderms (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neo-



mycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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Those parasites that live primarily in the duodenum or bile ducts often are more readily seen in the duodenal contents than in the stool. These include *Giardia lamblia* (motile trophozoites), *Strongyloides stercoralis* (larvae and/or eggs in advanced stages of development), *Clonorchis sinensis* (eggs), *Fasciola hepatica* (eggs), *Trichostrongylus orientalis* (eggs), and *Isospora* (coccidia).

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Multiple stool exams cultured over several weeks or duodenal intubation are the most commonly used procedures. The Entero-Test is as efficient as intubation but simpler and more comfortable. New studies have further confirmed superior applicability over other procedures.

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Chronic Diarrhea caused by anaerobic and aerobic bacteria in infants and children was easily identified using the Entero-Test. The string test was comparable to or better than duodenal aspirate in all cases.



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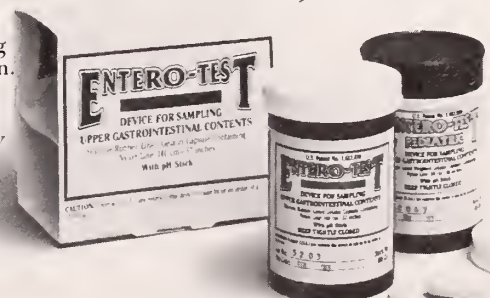
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Sanford A. Mullen, M.D. 105th President of the Florida Medical Association

When Sanford A. Mullen was installed as the 105th President of the Florida Medical Association, he brought to this office an exceptional breadth of knowledge and experience.

His first President's page in the June 1981 issue of *The Journal of the Florida Medical Association* established as his theme for the year, "Community Service by Physicians." His message was that practicing good medicine is not enough; physicians must also become involved in community affairs. He pointed out that the decision-making ability, the disciplined attitude, and the emotional maturity of physicians fit them well for participating in community affairs.

This theme was a most appropriate one, for Sanford has demonstrated by example that a physician can practice good medicine and at the same time be a community leader.

Tampa to Jacksonville • Sanford was born in Tampa but grew up in Jacksonville. He attended Mercer University, where he met his lovely wife, Minnie. After graduation from Columbia University College of Physicians and Surgeons, he began his postgraduate education in Internal Medicine but then changed to Pathology, in which he had residencies at Grady Hospital in Atlanta and the University Hospitals of the University of Minnesota. This residency training was interrupted, however, by a two-year tour of duty as a combat battalion surgeon in Korea.

Sanford entered practice in 1957 in Jacksonville, where he quickly involved himself in both medical and community affairs. These included appointments to many committees and councils of the Duval County Medical Society. He subsequently served as President of the Academy of Medicine of Jacksonville and as President of the Duval County Medical Society. Almost simultaneously, he became active in the Florida Medical Association, the Florida Society of Pathologists, and the Florida Association of Blood Banks. He later served as President of both the Florida Society of Pathologists and the Florida Association of Blood Banks.

His participation in the affairs of the Florida

Medical Association was extensive. It included serving as Chairman of the Council on Specialty Medicine, Chairman of the Council on Legislation, and both Vice Speaker and Speaker of the House of Delegates.

His responsibilities in national medical organizations are too numerous to mention.

Many Responsibilities in Medicine • It seems impossible for a physician in active practice to carry on all these organizational responsibilities in medicine and have time left over for community affairs, but Sanford did it. He served as President of the Rotary Club of Jacksonville and the Civic Round Table of Jacksonville, Chairman of the Mayor's Ad Hoc Advisory Committee on Water Pollution Control, and as a member of the Board of Governors and as Vice President of the Jacksonville Chamber of Commerce.

In recognition of this public service, the Florida Medical Association awarded him the A. H. Robins Award for Outstanding Community Service in 1973.

As he began his year as President of the Florida Medical Association, he established some important objectives for the Association.

These included developing mechanisms to deal with problems of health care financing, encouraging physicians to participate in business coalitions for health care cost containment, increasing the participation of the Auxiliary in the legislative and political affairs of the Florida Medical Association, strengthening the legislative program of the Florida Medical Association, encouraging participation by physicians in community affairs, improving relations between the Florida Medical Association and medical specialty societies, improving relationships with Florida's three medical schools, and supporting the staff organization of the Florida Medical Association being carried out in anticipation of the retirement of Executive Vice President, W. Harold Parham, D.H.A., as well as initiating a mechanism to address the professional liability insurance problem in Florida.

Health Care Financing • Significant progress was made toward all of these goals. The new Council on Health Care Financing has, through its multiple

committees, become deeply involved in dealing with health care financing problems. This Council was also involved in planning the outstanding program on health care financing that was presented at the 1982 Leadership Conference, and it also was involved in developing the Special Issue on Health Care Financing of *The Journal of the Florida Medical Association* of March 1982.

Sanford also initiated a separate legislative conference for the FMA in October 1981 in anticipation of the early meeting of the Florida Legislature in 1982.

Sanford has met with approximately 20 county medical societies and with many specialty societies. He has visited all three medical schools for meeting with the deans, members of the faculty and with some of the medical students.

He has given strong support to the Auxiliary of the Florida Medical Association. During the year, an additional Auxilian was added to the FLAMPAC Board of Directors and the Auxiliary has received increased staff and financial support. The Auxiliary has responded by becoming actively involved in FLAMPAC membership recruitment, voter registration, recruitment of volunteers for political campaigns, supporting the legislative program of the Florida Medical Association and involving itself in numerous community affairs.

Department of HRS • He has maintained a close working relationship with the Department of Health and Rehabilitative Services, especially during the change in administration from Alvin Taylor to David Pingree. He has met with Governor Graham on several occasions to discuss health issues in Florida. During the 1982 legislative session, Sanford visited the capital on a regular basis in active support of the legislative program of the Florida Medical Association. He was actively involved in planning the 1982 annual meeting program on aging.

He conducted meetings of the Board of Governors with dignity, efficiency and fairness.

Two thousand years ago, Tacitus wrote: "Reason and judgment are the qualities of a leader."

During this past year, Sanford has demonstrated that he has these qualities, as well as the capacity for hard work and motivation of others.

*F. C. Coleman, M.D.
Assistant Editor*



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Manifestation of grief: Effects on parents of child's acute illness

J. Michael Cupoli, M.D. and T. Berry Brazelton, M.D.

ABSTRACT: Parents move through a normal grief response to injury or acute illness of their child in two stages. Initially, they are disorganized, showing somatic and psychological symptoms; then they use their own coping mechanisms to integrate their grief and resolve their denial, anger, and guilt. Once resolved they can resume their supportive parental role. If not resolved and integrated, they become enmeshed in chronic grieving which is maladaptive for the family. The physician can aid in the initial stage with anticipatory guidance. A knowledge of the grief syndrome also allows the physician to understand the normal course of grief and the etiology of chronic grief and, thereby, better assist grieving families.

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In the everyday practice of medicine, the physician must cope with parents' responses to their children's acute illness or hospitalization. Grief is a reaction which we expect with the death of a loved one. It is also foreseen with an individual's awareness of his own death,¹ or when chronic illness impacts upon the family.²⁻⁴

We propose that the grief reaction should be expected of parents in their response to any illness in their child. A knowledge of the reaction is useful in the daily routine of physicians as they try to understand the behaviors of families under their care. Such an understanding allows the physician to organize his or her observations and produce a course of action to aid parents as they adapt.⁵

The diagnosis of illness in a family is always stressful. It implies the loss or change of a loved one because it brings to mind the real or imagined threat of death. Lindemann describes such a complex as "anticipatory grief."

We were at first surprised to find genuine grief reactions in patients who had not experienced a bereavement, but who had experienced a separation . . . Separation in this case is not due to death, but is under the *threat* of death . . . The parent is so concerned with *her adjustment* after the potential death of her . . . son that she goes through all the phases of grief.⁶ [emphasis ours]

This anticipatory grief may be conditioned by unresolved grief from the past.

In the pediatric literature, Solnit and Green's concepts of the "Vulnerable Child" describe the long-term effects of unresolved grief. Vulnerable children (1) were expected by their families to die due to serious illness; (2) because one parent identified the child with a figure from the past who died and (3) due to the mother's fear of her own death. These families appear to have been caught in a stage of anticipatory grief. The symptoms include difficulty with separation, infantilization of the child, bodily over-concerns, and

school underachievement. The effect of the syndrome on the family has an all-invasive quality. The vulnerable child and family are permeated with feelings of "doom" and "failure." The child senses his "vulnerability" and accepts the role. The symptoms all seem to be associated with separation anxiety and are characteristic of the grief reaction.

We now recognize the grief which results from a child's illness as a definite syndrome. It may appear with any crisis, which need not be a devastating or severe one. However, the patient and family are at risk because the grief may become distorted and maladaptive. We emphasize that the grief can be guided and modified by the caring physician.⁵

Nature of Grief Reaction • The grief reaction is normal. It is adaptive,⁸ has a characteristic course, and has physiological⁶ as well as behavioral⁹ components. The terms used in describing the manifestations of grief (sorrow, anger, guilt) as well as the mechanisms or process of grief (denial, regression, projection) are often used pejoratively by professionals. It is important for the physician to remember that the syndrome of grief and the defenses associated with it are coping mechanisms. "Coping" is the organization of adaptive and defensive reactions in such a way as to successfully respond to stress and the threat to psychological stability. Successful coping allows the parent to participate in the care of the child and to fulfill his other responsibilities.

The grief reaction, then, is a cluster of typical psychological and physiological behaviors. It allows the parent to utilize defenses that have been useful in the past. The reaction enables him or her to cope with feelings of inadequacy and self-depreciation. Thus, grieving is a strategy of successful coping. As such, it behooves the supportive physician to understand it and treat it as normal.

The coping process includes periods of disorganization, attempts at reintegration, and resolution by mature adaptation.¹⁰ Grief behavior may be best understood as occurring in two stages: (1) initial grieving, which includes disorganization and attempts at reintegration, and (2) integrated grief, which includes movement towards a mature adaptation.

Initial Grief Reaction • This stage includes initial disorganization with somatic manifestations, emotional shock and increased dependency, and strong denial. It includes feelings of self-depreciation, of helplessness, and an overwhelming sense of failure and guilt. These feelings are manifested by anxiety, anger, and hostility to those in charge, thereby masking the inadequate feelings of parents about themselves.

Somatic (or physiological) signs are those seen in any depression: crying, loss of spontaneity, loss of

sleep, decreased appetite, sighing respirations, and changes in sensorium. This early period may be brief, lasting minutes to hours, and is manifested by the parents' inability to organize themselves to be available to support the child's needs. The parent appears to be without direction and in need of support himself.¹¹ Lack of direction is a sign of emotional shock, but it is also the result of changes in sensorium. Grieving parents describe changes in perception, especially of time.

Even the "well-adjusted" family appears to have increased dependency and to need help with the easiest tasks.¹¹ They become lost on the way to x-ray or to the ward. Every admitting nurse or physician is familiar with a parent's inability to recall basic history and their distortion of time. This period is likely to be extended if the illness is unexpected, serious, or after an unexpected admission from the emergency ward.

The defense mechanism of denial may be manifested in many ways, depending on the style of the parent. In the parents' attempt to avoid the reality that their child is ill, they may (1) repeatedly question the diagnosis or the physician's assessment of the severity of the illness. Such denial can lead them to refuse or significantly delay appropriate treatment. It may even result in the child's discharge against medical advice. Other parents may (2) "doctor shop" or seek out a diagnosis more acceptable (less threatening) to them. Finally, parents may (3) ask the same questions over and over as if they never heard the physician's answers.

The parents' feelings of self-depreciation, helplessness and failure are manifested by anger. It may be projected toward others (hostility) or oneself (guilt). The need to blame others or oneself is more intense due to the common feeling that illness in a child is "unfair" or unjust.

Parental anger makes physicians most uncomfortable when it is aggressive. At times it appears the parent is purposefully trying to make the physician angry. Anger may also be manifested in a more subtle way, that is, by the defense of "identifying with the aggressor." Here, parents tend to take on the role of nurse or doctor which can result in the staff becoming defensive. This is likely to occur when parents need more availability and support from the staff. It is a grieving mechanism utilized to isolate affect and feelings from the cognitive reality of the illness.

A battle over care is heightened by the normal tendency for parents, physicians, and staff to compete for the care of the child and can result in conflict throughout the ward. Parents feel inadequate due to the child's illness. These feelings are heightened by the hospital's assumption of their role. Upsetting the delicate balance of roles may encourage passive behavior by some parents and they are likely to withdraw. This is a grief response. The failure of a parent to be on the ward is less often due to a lack of concern

and more often to unsettled, anxious and angry feelings.

Parents also may deal with anxiety by directing anger onto themselves. This results in feelings of intense guilt. A parent may give a long description of his or her own actions or failure to act as a primary cause of the child's illness. Such a history is often distorted by guilt.

Initial grief includes a period of shock and denial which is termed disorganization.¹⁰ If parents become frozen in this stage, the grief episode remains unresolved and becomes chronic. They become enmeshed in denial, anger, or guilt and unable to see themselves or the child apart from the illness. Such families are seen in practice as "over-protective", "angry," "hysterical," or hypochondriacal. They may treat their child as a "cardiac cripple", or continue to shop for doctors. Some will even try for a replacement child.

The grieving process may be guided toward a stage of reintegration with the help of the physician. Reintegration¹⁰ is a period of increased use of defense mechanisms that allows parents to move from concern with their own coping to a readiness to support the child's coping. This is the beginning of mature adaptation and more integrated phase of grieving.

Integrated Grief • It will be helpful to show the signs of a parent moving from initial to integrated grief by demonstrating each manifestation in order. The integrated stage of the grief reaction is one of mature adaptation.¹⁰ It is the mobilization of parental sources to care for the child.

As the integration of grief progresses, the parent's symptoms of depression are replaced by organized activity to give care to the child. The parent now appears to be stable. There are less outbursts of crying. The parent looks better, that is, less disheveled, more alert, and more relaxed. His or her history of the incident is clear, easy to elicit, and tends to be more helpful. As the parent moves beyond her own coping, she can deal directly with the child's real needs. At this time, the nurses observe her changing diapers, helping with feeding, taking walks, aiding other children, and not interfering with nursing care.

Denial is replaced by acceptance of the diagnosis, better understanding of the illness, and acceptance of therapy. They seek an active role in their child's care but in a positive, less aggressive way. In the initial phase, parents attempt to adopt the medical role. This period signals the end of repeated questioning and doctor-shopping. It begins the period of future-oriented questions concerning resumption of the child's normal activities and is marked by parents making use of therapeutic modalities.

The decreased anxiety helps the parent to be less guilty and less defensive. The level of anger is abated. Active acting out is less frequent. Passive resistance

is replaced by cooperative visiting and caring for the child. During this time, parents also have energy to help in the care of other children on the wards. They may still be angry at themselves and at their burden but they manage it more effectively. The integrated grief episode allows resumption of autonomous family life. Parents become secure in their roles, now relating to the child as a person rather than as a sick-role occupant.

Case Presentation • The patient, a ten-month-old girl, came to our Behavior Clinic so that her growth and development might be followed. She had been initially referred at six months of age with a diagnosis of "psychomotor retardation." Evaluation at that time demonstrated her to be two to three months behind in gross and fine motor development. Her abilities in the cognitive sphere seemed to be normal.

In our discussion with the mother, it was clear that the patient was getting excellent help at home — physical therapy at least an hour a day and weekly visits to physical therapists. In general, this family would be considered well-adjusted.

At the third meeting, we mentioned to the mother that at no time had she expressed discouragement, doubt, frustration or anger that her child was not the "normal child" that all parents expect. The mother cried and described her loneliness, feelings of loss, disappointment, and anger. These feelings had clearly been suppressed.

Going back to the neonatal period, we discussed the initial insult of having a child with mild congenital anomalies and the possibility of future retardation. We discovered that she had primarily dealt with her grief by emphasizing the physical therapy activity and had not specifically dealt with the emotional aspects. Her husband had also carried this grief and guilt without sharing it with her.

Their feelings were aired and shared, and we asked to see them a month later. At that time, they were beginning to describe physical therapy as a playing time and a relaxed time. They had made the distinction between being happy with their daughter's development and knowing when to move on and demand more without being concerned that they were demanding too much. They had changed from overconcern about what they had to "do", to the position that they could put some of the responsibility and expectations to perform onto the child.

By interviewing in a manner that is conventionally taboo, i.e., surfacing feelings that they considered their child to be abnormal, we were able to help them move through the grieving process from the initial to an integrated stage. Upon referral, this family had fulfilled all the criteria physicians usually have for being "good." They came to follow-up clinic, had all the immunizations, and went to all the appropriate specialists. Yet they were unable to express their fears that they were somehow at fault and had been responsible for the retarded child. The services we performed were to (1) separate the mental retardation fears from the motor retardation, and (2) invite them to express their own loneliness, fears, anger and guilt. By helping them to resolve their grief, we succeeded in encouraging a more growthful family relationship.

Discussion • Parents who present the physician with a child who is acutely ill may be experiencing a grief syndrome. It runs a course from an initial to an integrated stage. However, the resolution is not automatic and the physician may have an important role in directing movement to resolution.

The physician, as caretaker, may direct movement in the following ways. In the phase of initial

grieving, parents will experience anger and guilt. Their behavior may include acting out, competing with the physician's role, and/or withdrawal. The physician's best response is to listen to and accept the anger as normal and expected. This is much easier when he understands the anger is not directed personally to him or her but is a manifestation of the grief syndrome. Such understanding also makes it less likely that the physician and staff will respond with acting out behavior of their own. In response to parents' assumption of the physician role, the physician can support them by encouraging resumption of the normal activities of parenting. When parents' competition with the staff interferes with care, the physician may point out that their activity is not a real threat but a demonstration of their need for support as parents. The physician may relate to withdrawn parents by attentive and concerned listening which will allow them to express guilt. The physician also can point out the reality of the illness and help them move from excessive guilt to begin to reorganize around the real needs of the child.

There are several other steps physicians might consider in order to help families resolve their grief. By use of a detailed history, the physician and the parent can relive the first grief episode. The immediate reactions of loss, anger, guilt, and denial can be shared, credited as normal, and brought to the surface. Physicians can give a clear statement of how the vulnerable child is seen by the parents as damaged and different. They can point out that the symptoms come from both parents and child. Physicians can discuss the child's true state of health using a thorough physical examination. Without incurring increased guilt, they can lead parents to see how important it is for the child to be allowed to be independent and autonomous. Physicians can help the family with a positive view of the child and themselves with evidence of the child's strengths as well as their own. A useful technique is to observe the parent and child in the office and then describe their behavior, helping them to see themselves as effective parents. Other techniques are to reassure the parents in their role as

parents; to lead them to discuss how the illness had been stressful to them in this role, and to point out that grief may have clouded their vision, requiring help in reorganizing their view of themselves and of their child.

During the initial period of grief, the physician must deal with the child's illness but he must also be supportive to the parent's needs. Once the parents begin to deal with their initial reaction, they can then aid the physician and eventually resume full parental care. The physician who can recognize the move from the initial to the integrated phase of grief will be supportive earlier and then later be more demanding of the parents as they resume their full roles. The physician's role, then, is to deal with the child's illness but also to recognize and support the parents' grieving process.

Acknowledgements

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Should prophylactic lidocaine be routinely used in patients suspected of acute myocardial infarction?

Ken Grauer, M.D.

ABSTRACT: The case is made for prophylactic treatment with lidocaine of patients suspected of acute myocardial infarction. Primary ventricular fibrillation often occurs in the absence of warning arrhythmias and even when present many arrhythmias go undetected by the nursing staff. Intravenous lidocaine is effective in suppressing ventricular ectopy and is usually well tolerated in most patients. Its use may decrease the incidence of primary ventricular fibrillation and is recommended except for those patients with a low probability of infarction, the elderly, and patients who are seen over 24 hours after onset of symptoms.

Ventricular ectopy in the setting of an acute myocardial infarction is a definite indication for treatment with lidocaine. However, many patients with chest pain who are admitted to the intensive care unit for diagnosis of "rule-out MI" either do not have premature ventricular contractions (PVCs) and/or turn out to have conditions other than acute infarctions.^{1,2} Are the benefits of antiarrhythmic prophylaxis with lidocaine sufficient to justify its use in all these patients, or are we unnecessarily subjecting a substantial portion of them to the risks of lidocaine toxicity? Can we improve patient outcome by routinely administering this drug as soon as the diagnosis of acute myocardial infarction is suspected?

The answers to these questions are complex and depend on many factors including age of the patient, how well the drug is tolerated, and the number of hours from the onset of symptoms until initiation of therapy.

Primary ventricular fibrillation can be defined as ventricular fibrillation that occurs within the first few days (most commonly within the first few hours) of a myocardial infarction in the absence of cardiac failure or shock. It is seen in 5-10% of patients admitted with acute infarction.^{1,3,4} The secondary form of ventricular fibrillation is less common, usually occurs later than the primary form, and is the result of heart failure, hypotension and/or cardiogenic shock.⁵ It will not be considered here. The purpose of prophylactic lidocaine in the setting of acute myocardial infarction is to decrease the incidence of primary ventricular fibrillation in the hope that the associated mortality will also decrease.

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Warning Arrhythmias and their Detection

- In the past, much attention has been given to the

concept that primary ventricular fibrillation is commonly preceded by premonitory arrhythmias (i.e., five or more PVCs per minute, two or more PVCs in a row, multifocal PVCs, or the "R-on-T" phenomenon). Detection of any of these "warning" arrhythmias in a patient with or suspected of having an acute myocardial infarction was a signal to administer a bolus of lidocaine and begin an intravenous infusion. In recent years this concept has been seriously challenged, and a number of investigators have demonstrated that primary ventricular fibrillation may occur in the absence of any warning arrhythmias.^{1,4,6,7} In addition, many patients who have warning arrhythmias never develop primary ventricular fibrillation, so that the presence or absence of warning arrhythmias is no longer believed to serve as a good predictor for determining which patients will develop primary ventricular fibrillation.

Recognition of arrhythmias is another problem. Over 95% of patients with acute myocardial infarction have PVCs during the first 48 hours of their course.³ Surprisingly, much of this ventricular ectopy goes undetected in even the best of intensive care units.³ In a study by Romhilt et al,⁸ the detection rate for simple ventricular arrhythmias (i.e., unifocal PVCs) was under 50% when the nursing staff was compared to a computer system. Success at picking up complex ventricular arrhythmias (i.e., two or more PVCs in a row or multifocal PVCs) was even less. This implies that if lidocaine is withheld until ventricular arrhythmias are documented, significant delay will occur in some patients before treatment is begun.

Effect of Prophylactic Lidocaine • Is prophylactic treatment with lidocaine effective in lowering the incidence of primary ventricular fibrillation in patients with acute myocardial infarction? The experience of Lie suggests that it is.⁶ Of 212 patients under 70 years of age who were admitted to the hospital within six hours of infarction, primary ventricular fibrillation did not occur in any of the 107 patients who received prophylactic lidocaine but did occur in nine of the 105 (8.6%) untreated patients. Similar findings were obtained in a larger series by Wyman⁴ in which the incidence of primary ventricular fibrillation was reduced from 6.5% in untreated patients to 0.3% in over 1,000 patients who were given prophylactic lidocaine.

The study by Lie brings up several additional points of interest including the importance of the age of the patient and time elapsed since onset of symptoms. The risk of developing primary ventricular fibrillation in the setting of acute infarction appears to decrease with age. In patients 70 or over, this risk is estimated to be 1.3% compared to 6.5% for patients aged 50-69 and 13% for those under 50.¹ Lie only included patients under 70 in his study. This means

that his patient population faced a relatively high risk of developing primary ventricular fibrillation and lends support to his conclusion that antiarrhythmic prophylaxis is beneficial.

Lidocaine is the drug most commonly chosen by physicians for prophylactic treatment in the setting of suspected or proven myocardial infarction. It is effective, easy to use, and well tolerated in most patients. However, this medication is not totally benign and its use may be associated with up to a 15% incidence of side effects (drowsiness, paresthesias, dizziness, confusion, euphoria and occasionally seizures).^{6,9} Such adverse reactions are much more likely to occur in the elderly, raising the question of whether the benefits of prophylactic lidocaine might not be outweighed by the risk of toxicity in patients over 70.^{1,6}

Ventricular fibrillation most commonly occurs during the first one to two hours following onset of symptoms. Beyond this initial danger period the risk of this complication rapidly decreases so that less than one third of the cases of primary ventricular fibrillation occur after the first six hours.^{1,10} In his study Lie only included patients seen within six hours, again selecting a patient population at high risk of fibrillation who stood to benefit most from treatment. The case is made for treatment with prophylactic lidocaine for patients suspected of acute myocardial infarction who are under 70 and are seen early in their course regardless of whether or not they have warning arrhythmias. If a patient is seen more than 24 hours after onset and is still not having ventricular arrhythmias, prophylactic treatment with lidocaine may no longer be warranted.

Arguments Against Prophylactic Lidocaine • The most convincing argument against the routine use of prophylactic lidocaine is that mortality is unaltered.⁶ Eight out of the nine patients in the untreated group of the Lie study who developed primary ventricular fibrillation were successfully defibrillated. The ninth succumbed to recurrent bouts of ventricular fibrillation that were unresponsive to both antiarrhythmic therapy and repeated defibrillation. This high rate of successful resuscitation is comparable to that obtained in other studies^{1,11,12,13} and may be attributed to the prompt intervention possible in an acute care setting. On the other hand, patients who develop ventricular fibrillation secondary to heart failure, hypotension and/or cardiogenic shock have a much poorer prognosis whether or not they are treated with lidocaine.

The second argument against the routine use of lidocaine is that about half the patients admitted to the intensive care unit with a diagnosis of "rule-out MI" will turn out not to have an acute infarction.^{1,3,14} Universal treatment with lidocaine would result in the unnecessary exposure of large numbers of patients to the risks of toxicity from the drug.

Rebuttal • Although prophylactic lidocaine has not been shown to decrease the mortality from acute myocardial infarction, its use can be justified on the grounds that it lowers the frequency of primary ventricular fibrillation and the need for defibrillation. In addition, many of the patients with chest pain who don't infarct will have unstable angina. These patients also face an increased risk of arrhythmia and sudden death and will benefit from prophylactic lidocaine.

Finally, although adverse reactions from lidocaine are not uncommon, most of these are minor and can be minimized by monitoring serum drug concentrations and lowering the infusion rate for those patients most predisposed to developing toxicity (i.e., those with low body weight, congestive heart failure, or the elderly).^{1,9}

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Giant hyperplastic polyps associated with vasculitis of colon

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ABSTRACT: Hyperplastic polyps are usually small sessile lesions that are typically asymptomatic without malignant potential. We report a case of giant hyperplastic polyps associated with rheumatoid vasculitis and mimicking colon carcinoma. This case highlights the difficulty of differentiating hyperplastic from multiple neoplastic polyposis on the basis of radiographic and endoscopic appearance alone. The association of colonic vasculitis and giant hyperplastic polyps has not previously been reported.

Hyperplastic polyps are the most common type of polyp found in the colon. The vast majority are small, asymptomatic lesions that are usually incidental findings with no malignant potential.¹ In contrast, a patient with long-standing rheumatoid arthritis presented with a multinodular friable rectal lesion that was very suggestive of malignancy. Certain aspects of his course including the possible relationship between the rectal lesion and rheumatoid arthritis have important clinical implications. The details of this case are reported.

Report of Case • A 55-year-old white male presented to the Tampa VA Hospital in November 1978 with a four month history of soft, watery, mucoid stools associated with hematochezia. The number of bowel movements had increased to three to four per day. He denied any history of constipation, abdominal pain, weight loss, anorexia or previous gastrointestinal diseases. Past medical history was noteworthy only for rheumatoid arthritis since 1950 for which he had been treated with intermittent aspirin therapy. He denied taking any other medications or having any allergies. He smoked one and one-half packs of cigarettes per day.

Physical examination revealed a well developed, mildly obese white man in no acute distress. Vital signs were normal. Examination of the abdomen revealed minimal splenomegaly. The liver was 11 cm in span along the lateral border of the right rectus muscle. Bowel sounds were normal. No masses were palpated and the abdomen was nontender. Rectal examination revealed soft polypoid nodules circumferentially. Stool was brown and positive for occult blood. There was synovial thickening of the metacarpophalangeal and proximal interphalangeal joints of both hands as well as both wrists, elbows and ankles. There was decreased range of motion and tenderness of these joints as well. Bilateral rheumatoid nodules were noted over both elbows.

Laboratory data on presentation revealed hemoglobin 12.3 gm and hematocrit 36% with normal indices, differential, white blood cell count and platelet count. Prothrombin time, PTT, SMA-6 and 12 were all within normal limits. Scan revealed diffuse liver disease and mild splenomegaly. A CEA level of 4.2 mg per ml was obtained.

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Sedimentation rate was 50 mm per hour. A rheumatoid factor was positive with a speckled pattern at a dilution of 1:20.

Proctosigmoidoscopy showed several erythematous, nodular and friable polypoid lesions beginning 3 cm above the anus. These lesions were all sessile and at 11 cm appeared to involve the entire circumference of the rectum preventing further insertion of the sigmoidoscope. Air contrast barium enema revealed irregular, polypoid filling defects in the rectosigmoid region with a normal proximal colon.

Colonoscopy was performed to determine the extent of the process and to further evaluate the proximal colon. It revealed 13 sessile polyps located between 3 and 28 cm from the anal verge (Fig. 1). Ten of the polyps were oval, erythematous and sessile and ranged from 0.5 to 2 cm in diameter. Three polyps had a longitudinal or serpiginous configuration with a length of up to 5 cm and width of 2 to 3 cm. The larger lesions were also sessile and erythematous. All the polypoid lesions were soft and in several areas superficial ulcerations were present. When the rectum was adequately distended with air, no circumferential lesions could be identified. The proximal colon was completely normal.

Despite multiple colonoscopic biopsies which were interpreted as hyperplastic polyps with extensive acute and chronic inflammation, a clinical diagnosis of diffuse polyposis of the rectum and sigmoid colon possibly associated with adenocarcinoma of the rectum was made and the patient underwent proctectomy. At surgery, an inflamed and edematous mesosigmoid and retroperitoneum were noted. The surgical specimen contained 15 hyperplastic polyps up to 5.4 cm in largest diameter (Fig. 2) with superficial mucosal ulcerations (Fig. 3A and 3B). Focal arteritis with foci of fibrinoid necrosis possibly secondary to rheumatoid vasculitis was also present (Fig. 4). No evidence of adenomatous or malignant change was present. Review of the previous proctoscopic biopsy also revealed hyperplastic polyps. The patient tolerated the procedure well and was discharged with a well functioning colostomy.

Discussion • This is a case of large, multiple, friable hyperplastic rectosigmoid polyps that presented with hematochezia and diarrhea. These features gave an endoscopic and radiographic appearance similar to a malignant or premalignant lesion. They were therefore treated with radical resection despite lack of histologic proof of malignancy. This is a very atypical presentation for hyperplastic polyps.

Hyperplastic polyps usually are small sessile polyps found in the rectosigmoid region that are very common with increasing age.^{2,3} Approximately 40% of adults under 40 years of age and 75% over 40 have been shown to have hyperplastic polyps in their colons. The color is usually the same as the surrounding mucosa in contrast to the erythematous adenomatous polyp.² Hyperplastic polyps grow slowly to between 1 and 5 mm in size and either remain unchanged in size, slowly regress and disappear, or rarely, grow up to 2 cm in size (especially in patients with inflammatory bowel disease).^{4,5} The polyps are usually multiple and on very rare occasions can be mistaken for polyposis coli.⁶ Typically, these polyps are asymptomatic incidental findings which have no malignant potential.⁴

Microscopically, hyperplastic polyps are composed of villi with uniform sawtooth tubules and mature goblet and absorptive columnar cells. The



Fig. 1. — Endoscopic photograph demonstrating a sessile, erythematous polypoid lesion with superficial ulceration.

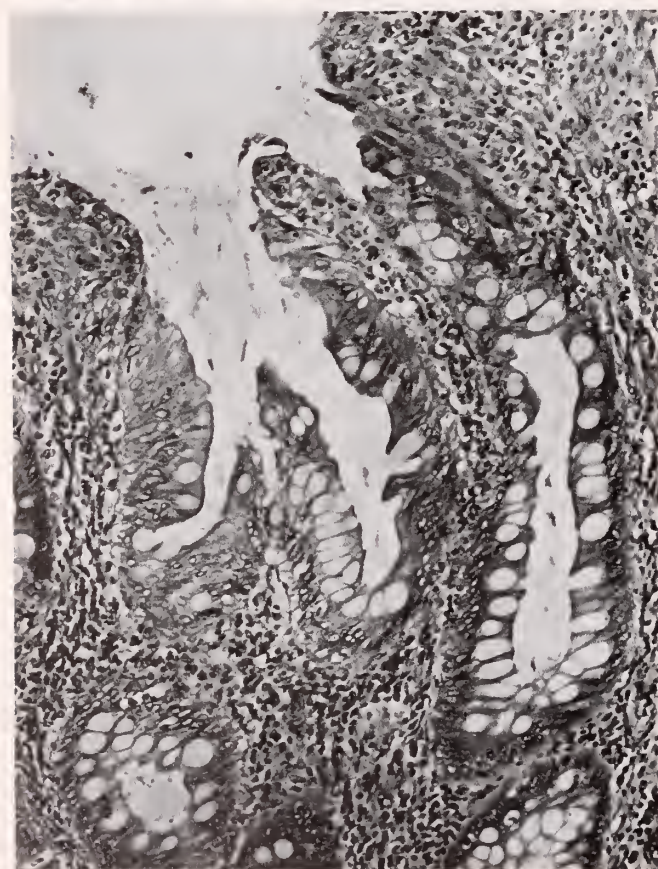
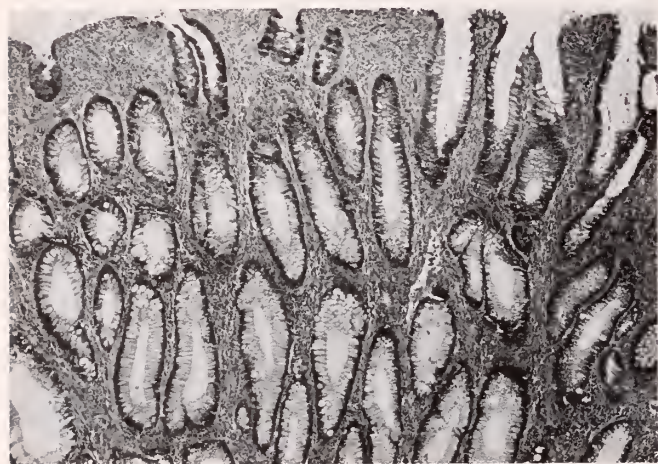


Fig. 2. — Rectosigmoid surgical specimen showing multiple polypoid lesions. A few are small round mucosal elevations that measure less than 0.5 cm. Most of the lesions are longitudinal, serpiginous ridges of elevated mucosa averaging 0.6 cm in width and 1 to 5.4 cm in length. The mesosigmoid is edematous and thickened.

supporting pericryptal fibroblasts are fully differentiated and excessively developed.⁷ The pathogenesis of this hypermaturation is a delay in both the migration of mature cells from the crypts and their extrusion from the tips of the villi.⁸ This exaggeration of normal colonic differentiation is in sharp contrast to the incomplete differentiation seen with adenomatous polyps.⁷ The etiology of these changes is felt to be related to aging rather than to inflammation as thought in the past.⁴

Since a variety of nonneoplastic, rectal mucosal lesions including colitis cystica profunda, pseudopolyps secondary to inflammatory bowel disease or schistosomiasis, and large hyperplastic polyps may mimic malignancy it is mandatory to establish a

definitive histologic diagnosis before radical surgery is undertaken. Although small endoscopic biopsies may not be representative, sampling error can be minimized by taking multiple biopsies and brushings for cytology. It may not always be possible to demonstrate invasive carcinoma within a mucosal neoplasm by endoscopic biopsy, however, multiple biopsies are helpful in differentiating nonneoplastic lesions which have no malignant potential from true adenomas which are premalignant lesions. Although certain gross, anatomic features of the large hyperplastic polyps in this case were indistinguishable from a malignancy, the benign, nonneoplastic nature of these lesions were correctly identified by colonoscopic biopsies.



The association between the hyperplastic polyps and the rheumatoid arteritis has not been previously reported. Arteritis has been recognized as an extra-articular manifestation of rheumatoid arthritis for more than 25 years. It usually occurs in seropositive patients with severe active disease.¹⁰ When present in the intestinal tract, it may involve the small arteries leading to multiple ischemic ulcerations with hemorrhage or perforation.^{11,12} If the arteritis involves the larger arteries, it may result in extensive segmental infarction and gangrene.^{11,13} The arteritis may have contributed to the atypical presentation of the polyps in this patient by producing ischemic erosions and consequent friability. There is no definite evidence that the arteritis was directly responsible for development of hyperplastic polyps in this case.

In conclusion, this case highlights the potential difficulty in differentiating hyperplastic from neoplastic multiple polyposis by clinical appearance. Importance of this differentiation in terms of therapeutic consequences is obvious. Preoperative pathological confirmation of the diagnosis in these cases is essential.

Fig. 3. — (A and B) Hyperplastic mucosa with typical saw-toothed glands and increased numbers of mature absorptive and goblet cells. The superficial lamina propria shows severe chronic inflammation. In addition, superficial epithelial erosion is present with regenerative changes. (A. H&E 40X; B. H&E 60X).

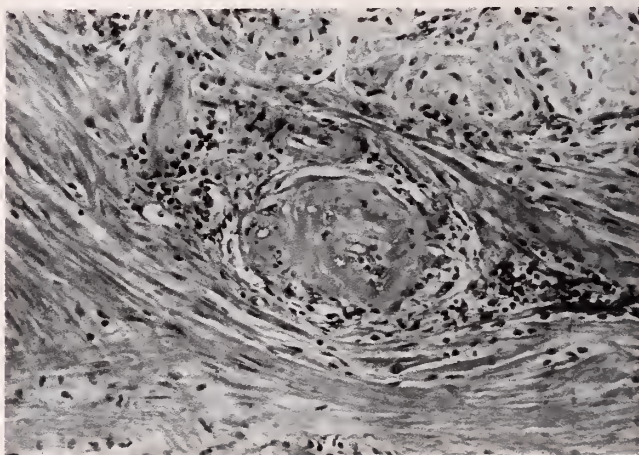


Fig. 4. — This small artery within the muscularis propria exhibits changes typical of an arteritis with uniform fibrinoid necrosis, endothelial hypertrophy and mild perivascular, predominantly lymphocytic, infiltrate (H&E 60X).

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Acute phase serologic diagnosis:

Rapid diagnosis of infection by detection of IgM antibodies

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*ABSTRACT: Serologic techniques have traditionally been used to diagnose certain infectious illnesses based on a four-fold rise in antibody titer over a designated time period, usually two to three weeks. New serologic techniques allow detection of specific antibodies present in acute phase of such illnesses, thereby allowing specific diagnosis in a clinically useful time frame. This discussion outlines the basic immunologic principles for these tests, some specific applications, and potential limitations of the techniques. Pulmonary infections due to *Legionella pneumophila* (Legionnaire's disease) have been of particular interest in establishing acute phase serologic testing in our laboratory.*

The diagnosis of selected infectious illnesses, particularly viral syndromes and other "difficult-to-diagnose" infections such as Legionnaire's disease or toxoplasmosis, has traditionally relied on serologic techniques. These laboratory tests are based on the knowledge that antibodies directed against specific organisms are produced as a result of infection with (or exposure to) the organism. However, the requirement for "acute" and "convalescent" serum samples for serologic diagnosis, usually at 2-3 week intervals, places significant limitations on the clinical usefulness of these tests. Recent advances in cell culture techniques and in reagent antibody production have sparked a renewed interest in diagnosis by serologic techniques, based on knowledge of the early responses of the immune system. The potential for making an "acute phase" serologic diagnosis of specific infections has far-reaching implications related to prognosis, infection control, specific antibacterial therapy, and avoidance of unnecessary but potentially toxic therapy. A brief review of the immunologic principles of acute phase serologic diagnosis, a discussion of methodology, and limitations of these techniques is presented.

Immunologic Basis for Specific IgM Testing

• Following the initial exposure of the host to the offending agent, immunologically competent individuals produce circulating immunoglobulin M (IgM) class antibodies directed against antigens unique to the invading organism. These "acute phase" antibodies are usually present at the time patients become symptomatic, or soon thereafter, and persist at detectable levels for as long as three months. Shortly after these IgM class antibodies are produced, specific

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IgG antibodies against the offending agent are produced; these persist for years and are referred to by some as "immune phase" antibodies. These antibody responses are diagrammatically illustrated in Figure 1.

In general, traditional serologic tests have measured IgG class antibodies, or at least have been unable to distinguish between IgG and other classes of antibodies. Thus, a single measurement showing the presence of antibodies against an agent can only be interpreted as evidence of some previous exposure at an unknown time. Detection of specific IgM class (acute phase) antibodies, on the other hand, is interpreted as indicating an acute, ongoing process. Thus, the need for a convalescent serum to observe a four-fold rise in titer is obviated and definitive therapy can be instituted (or "shotgun" therapy withdrawn). A negative result must be interpreted cautiously since the sample may have been taken before an antibody response occurred. However, the study can be repeated after several days; this interval will usually be sufficient for the production of acute phase antibodies, although individual variations in response have been observed.

Clinical Applications • Acute phase serologic diagnosis, then, refers to the detection of specific IgM class antibodies during the acute phase of an illness. The list of illnesses now diagnosable with this technique is rapidly expanding including viruses (such as hepatitis A, rubella, cytomegalovirus, Epstein-Barr virus, others), bacteria (*Legionella pneumophila*, *Mycoplasma pneumoniae*), and protozoans (*Toxoplasma gondii*), and tests for organisms other than those listed are currently under development by commercial sources. These tests for the most part involve relatively simple instrumentation and are not technically difficult to perform, although some experience in interpretation is required. Indirect immunofluorescent tests are most common at present, but enzyme linked immunoassays (ELISA) have been introduced in some areas, and radioimmunoassay (as in hepatitis-A IgM testing) is also useful in detecting "acute phase" (IgM) antibodies. The indirect immunofluorescent test is performed by incubating dilutions of the patient's serum with virus-infected, fixed, tissue culture cells, usually layered onto glass slides.

of IgG and IgM class are detected by adding fluorescein conjugated antihuman IgG or IgM, produced in laboratory animals, and then examining these slides with a fluorescent microscope. Fixed suspensions of bacteria or protozoans may be substituted for infected tissue culture cells (as in the tests for *Legionella pneumophila* or *Toxoplasma gondii*). Standardized, pre-packaged kits for some of these determinations are available from a number of commercial sources.

Testing for IgM class antibodies to *Legionella pneumophila* can be performed using a modification of the procedures developed at the Center for Disease

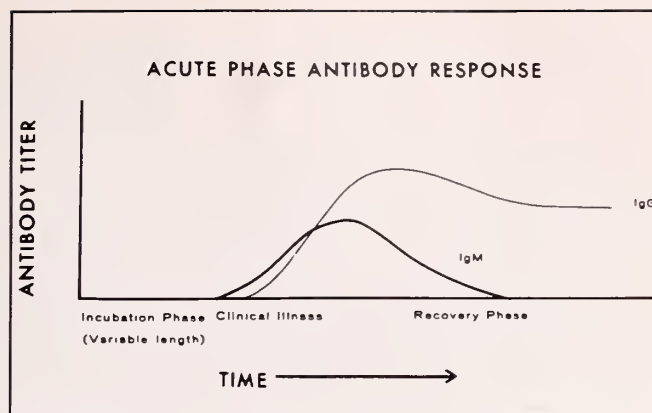


Figure 1.

Control [CDC]. We have performed this test in our own clinical laboratory for the past 12 months using IgG and IgM specific antisera obtained commercially in an indirect immunofluorescent procedure. Initially, we confirmed our positive results by sending many paired sera to CDC; however, after only a few months we discontinued this practice because of the excellent correlation between acute phase antibody (IgM) detection and eventual seroconversion by traditional methods. Similar experiences have been shared by others in this country and in England. Occasional cases have given negative results when studied early in their illness, but have shown detectable levels of specific IgM when restudied as soon as seven days later. These studies have established acute phase *Legionella* serologic studies to be of clinical diagnostic and therapeutic relevance rather than merely epidemiologic tools. The following cases from our acute phase serologic testing experience serve to illustrate its contribution.

Report of Case • Case 1. — A 64-year-old woman was admitted to the hospital in the fall of 1980 with a 4-5 day history of fever, cough, and bilateral pulmonary infiltrates on chest x-ray. Her admission laboratory data were inconclusive and sputum cultures were reported as "normal respiratory flora." Acute phase serologic studies for *Legionella pneumophila* and *Mycoplasma pneumoniae* were requested and were performed on the 5th hospital day: for *Legionella pneumophila*, IgM = 1:64, IgG = 1:128; for *Mycoplasma pneumoniae*, IgM = 1:8, IgG = 1:8. A presumptive diagnosis of Legionnaire's disease was made and she was treated with erythromycin and recovered uneventfully. Subsequent serologic testing confirmed even greater titers of both IgG and IgM specific for *Legionella pneumophila* and continued negative results for *Mycoplasma pneumoniae*.

Case 2. — A 52-year-old woman was admitted to the hospital with acute gastrointestinal bleeding. She had a long history of alcoholism with hepatic cirrhosis. During her rather stormy hospital course, fever developed and bilateral pulmonary infiltrates on chest x-ray persisted despite antibiotic therapy. Acute phase serologic testing for *Legionella pneumophila* gave the following titers: IgG = 1:128, IgM = 1:16. Because of the absence of IgM class antibodies, it was believed that the IgG antibodies probably indicated some past exposure rather than a current infection. Subsequently, an open lung biopsy was performed which showed histologic findings of diffuse alveolar damage, consistent with adult respiratory

distress syndrome (ARDS). Culture of the biopsy specimen on special media were negative for *Legionella* as were direct fluorescent antibody studies on lung imprints and tissue sections.

Case 3. — A 29-year-old hospital employee was seen by the Employee Health Service with symptoms of malaise, low grade fever, and weakness of about one week duration. He had no significant lymphadenopathy but had mildly abnormal liver function tests. His CBC showed many atypical lymphocytes suggestive of infectious mononucleosis but mono spot tests were negative. Acute phase serologic testing for cytomegalovirus showed IgM titers of 1:32, IgG 1:128. Repeat mono spot tests in the convalescent phase remained negative, the CMV IgG titer rose to $\geq 1:512$.

These cases illustrate several advantages of acute phase serologic diagnostic testing. In Case 1, the serologic findings were typical of acute infection due to *Legionella pneumophila*, and prompt therapy with erythromycin was instituted. Paired sera sent to CDC were reported as showing a greater than four-fold rise in titer, but these results were not available until about six weeks after the initial sample was drawn. The second case illustrates the role of IgM specific antibody testing in distinguishing between a current infection versus residual "immune phase" antibodies. A single titer of 1:128 without determination of the specific classes of antibody present is of little value and in fact could be confusing. The absence of specific IgM was in favor of some other etiology of this patient's pulmonary problem. The third case illustrates the potential role of IgM antibody testing in so-called "atypical mononucleosis syndromes" (i.e., mono spot-negative). Epstein-Barr virus and *Toxoplasma gondii* have also been shown to contribute to this heterogeneous group.

Limitations • Acute phase serologic tests, like all laboratory tests, have some limitations. Certain viruses in the herpesvirus group may remain latent for extended periods after a primary infection only to surface again after some triggering event. These patients may develop persistently high IgG specific antibody titers which could mask the presence of lower IgM titers seen with reactivation of the virus. The presence in the serum of antiglobulins of the IgM class (i.e., rheumatoid factors) in patients with existing specific IgG antibodies may produce "false-positive" IgM titers. Rheumatoid factors of this type have been a considerable obstacle in specific IgM testing of neonates in efforts to diagnose intrauterine

infections. These interferences have been uncommon in our experience, which includes mainly an adult population, but have been encountered. Methods to circumvent these problems include fractionation of sera and absorption of rheumatoid factors prior to testing, and simplified techniques for these procedures are currently under development.

Summary • The diagnosis of certain infectious diseases remains primarily based on serologic studies which in their traditional format have too often been of value only as epidemiologic tools. Acute phase serologic tests, that is, detection in the serum of IgM class antibodies to specific microorganisms, have brought rapid serologic diagnosis within the scope of clinical laboratories where tissue culture facilities or animal inoculation are not available. Specific acute phase diagnosis in pulmonary diseases already carries obvious therapeutic implications. With the advent of effective antiviral agents, the need for more accurate, rapid viral diagnosis will become even more urgent. As with all laboratory tests, appropriate patient selection, controls, knowledge of limitations, and careful interpretation of results will improve the diagnostic specificity in borderline or atypical cases. With the accumulation of clinical experience in acute phase serologic testing for Legionnaire's disease, appropriate therapeutic strategies can be developed based on clinical presentation, results of bacterial cultures, and careful serologic examination.

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A complete list of references is available from the author on request.

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Giant epidermoid cyst of spleen:

Case report with nuclear medicine, sonographic and pathologic studies

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ABSTRACT: A Tc-99m sulfur colloid liver/spleen scan of a 24-year-old woman with a large mass in the left upper quadrant of the abdomen revealed a large area of absent radioactivity, which was subsequently shown to be sonolucent and, therefore, a cyst. Splenectomy was performed and pathologically the lesion was proven to be a giant epidermoid cyst. The present concern of preserving splenic tissue in order to maintain competence of the immunohematologic system as a part of management of an epidermoid cyst of the spleen is discussed.

Cysts of the spleen can be divided into two categories: parasitic and nonparasitic. The parasitic cyst is caused primarily by echinococcus infestation, and focal splenic involvement is rare in the United States.¹ The nonparasitic splenic cyst can be subdivided into (a) traumatic or nonepithelial lined² and (b) true epithelial lined. The epidermoid cysts belong to the later category, which is a developmental abnormality.³⁻¹³

A young woman presented with a mass in the left upper quadrant of the abdomen. Radiocolloid scan and sonography suggested a splenic cyst which was identified as an epidermoid cyst after removal.

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Case Report • A 24-year-old woman was admitted for evaluation of a left upper quadrant abdominal mass. She had a normal pelvic delivery of a full-term female infant two months previously after an uncomplicated pregnancy. The patient noted some asymmetry to her abdomen about three to four months before she became pregnant. She had no chills, fever, pleuritis, adenopathy or other systemic symptoms and complete review of systems, past medical history and surgical history were all unremarkable. Her average weight was 126 pounds, which increased to 148 pounds during pregnancy and then decreased to 126 pounds after delivery. Postpartum she was again aware of the swelling in her left upper abdomen.

Physical examination was unremarkable except for a large mass present in the left side of the abdomen which extended to the iliac crest and was 20 to 25 cm in diameter. The mass was fairly firm, did not move with respiration but was believed to be the spleen. It was not tender and slight back pain was induced when pressure was applied. CBC, bone marrow aspiration and SMAC chemistry profile were normal.

The Tc-99m sulfur colloid scan (Fig. 1) revealed massive splenomegaly with an area of absent radioactivity approximately 20 cm in diameter located in the superior-lateral aspect of the organ. There was a broad rim of radioactivity along the inferior-posterior portion of the spleen suggesting that the mass was intrasplenic.

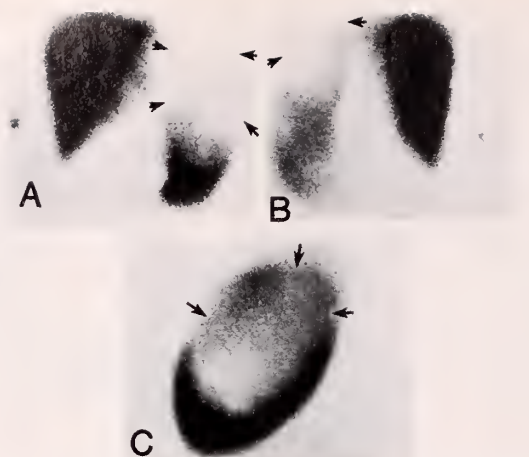


Fig. 1. — Tc-99m S colloid liver/spleen scan. A. Anterior view; B. Posterior view; C. Left lateral view. Note massive splenomegaly with a large area of absent radioactivity mainly located in the superior-lateral aspect of the organ (arrows). There is a broad rim of radioactivity along the anterior-posterior portion of the spleen. The liver is normal.

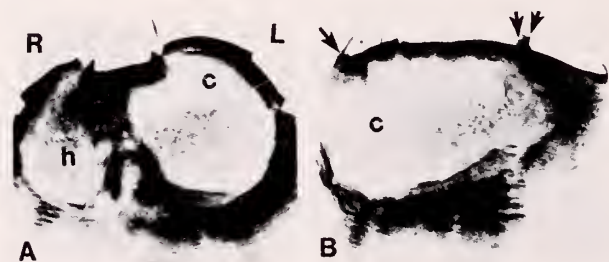


Fig. 2. — Gray Scale Sonography. A. Transverse, 10 cm caudal to xyphoid; B. Longitudinal, 14 cm to the left of midline; arrow, xyphoid process; double arrow, umbilicus; R, right side; L, left side; h, liver; c, cyst of the spleen.

The liver was normal. A sonogram of the spleen revealed low internal echoes in the spleen and that the mass was sonolucent (Fig. 2). A diagnosis of a large solitary intrasplenic cyst was made.

A splenectomy was performed. Approximately 2800 ml of turbid, brown fluid with fibrinous material was drained from the cyst. The removed spleen, after total evacuation of fluid, weighed 450 grams and measured 22 x 13 x 5 cm. The cyst measured 20 cm in diameter. The inner surface of the cyst revealed prominent trabeculation, resembling chordae tendinae of the heart (Fig. 3A). The external surface was white to yellow in color (Fig. 3B). Microscopic examination confirmed a squamous cell lined cyst with a broad fibrous cystic wall (Fig. 4). The splenic tissue outside the cyst was normal.

The postoperative course was uneventful. The patient was healthy and without complaints when examined one year later.

Discussion • Seventy-nine cases of epidermoid cysts have been reported. The patient ages range from six months to 50 years; the average age is 16.7 years (Fig. 5), with a slight predominance of women (3:2).^{3-13,14,16} The proposed pathogenesis of the lesion is the migration of the mesothelial cells lining the

primitive coelomic cavity into the splenic anlage during embryogenesis with subsequent squamous metaplasia of these lining cells.¹² Griscom et al described a newborn with a large splenic cyst lined by simple squamous or flattened stratified squamous epithelium similar to that found in later childhood and adolescence.¹³ That report supports the developmental rather than the traumatically acquired hypothesis.

The differential diagnosis of splenomegaly with a mass defect lesion on Tc-99m sulfur colloid scan include splenic hematoma, infarct, metastatic carcinoma, vascular sarcoma, Hodgkin's disease, lymphoma, lymphangioma, echinococcus cyst, or a primary cyst. A radionuclide blood pool study using Tc-99m pertechnetate^{6,14} or In-113m chloride^{15,16} or Tc-99m RBC labeling¹⁷ may be useful to differentiate a vascular from an avascular lesion, however this technique was not utilized in this patient.

Of all splenic mass lesions, a cystic lesion is uncommon¹⁸ but an ultrasound study may rapidly differentiate between a solid and a cystic mass. Gray scale sonography identified a solitary cyst with low level internal echoes (Fig. 2). We believe that the internal echoes are due to fibrinous material present in the cystic fluid. The echinococcal cyst usually has septation and contains multiple daughter cysts.¹⁹ Lymphangioma of the spleen consists of numerous endothelium-lined cystic spaces of various sizes and are usually highly echogenic.²⁰ Utilization of an abdominal CT-scan is an alternative method to differentiate cystic from solid mass lesion. Two cases of cystic lesion of the spleen have been reported, one a pseudocyst and the other an epidermoid cyst occurring in the intrapancreatic accessory spleen.^{21,22}

A true splenic cyst is lined with epithelial cells while a pseudosplenic cyst is nonepithelial lined. The latter are statistically more common than the former and more frequently associated with trauma.² It is impossible to distinguish an epithelial-lined cyst from a nonepithelial-lined cyst by clinical manifestations, nuclear medicine tests, sonography, abdominal CT scan or even gross pathology. Definitive diagnosis of an epithelial-lined cyst is by microscopic examination (Fig. 4).²

The traditional therapy for epidermoid cyst is splenectomy; however, the role of the spleen in the prevention of infection has been recently emphasized. The increased incidence of sepsis in splenectomized children and possibly in adults is well documented.²³⁻²⁶ Preservation of the spleen, in whole or part, following accidental injury has been used increasingly and there are now 227 reports of partial splenectomy and/or surgical repair of the spleen.²⁶ A high incidence of epidermoid cyst is seen in adolescents, as shown in Figure 5. The splenic tissue apart from the cyst, as was so in this case, appears to be normally histologically. Preservation of reticuloendothelial splenic function is implied by the visualization of the inferior portion

of the organ on the radiocolloid scan (Fig. 1A). The strategy for future therapy of benign cystic disease of the spleen should consider preservation of the remaining functioning splenic tissue as demonstrated by sulfur colloid scans in addition to the relief of symptoms by reducing disfiguring abdominal protuberance. If it were possible to confirm the diagnosis, and rule out neoplasm or parasitic cyst (where splenectomy would be indicated), decompression of the cyst and/or partial splenic resection might be considered appropriate conservative management.

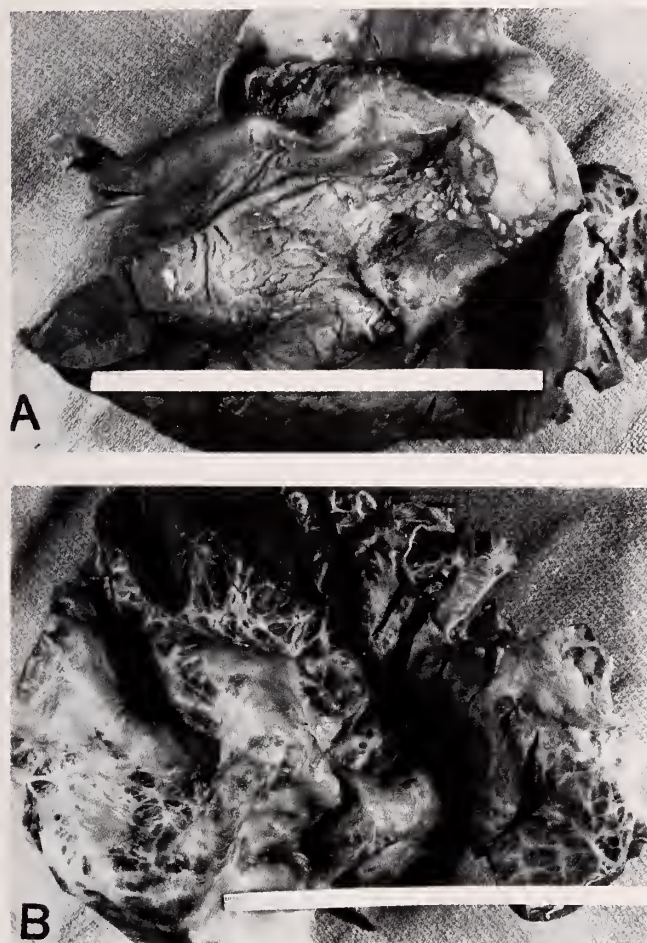


Fig. 3. — Gross photographs of the decompressed spleen. A. External surface of spleen; B. Interior of the cyst; note smooth, shiny, trabeculated surface resembling chordae tendineae of the heart.

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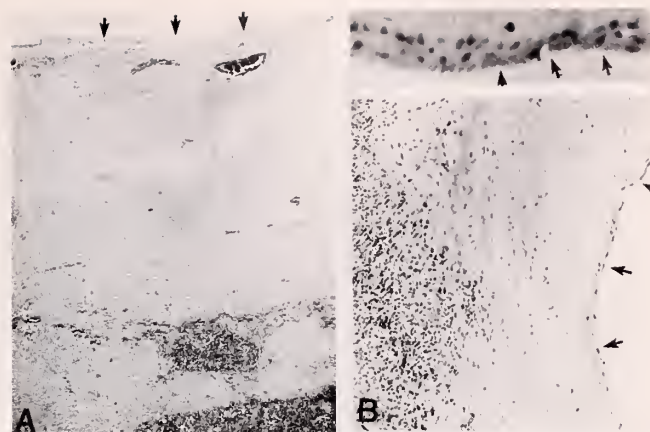
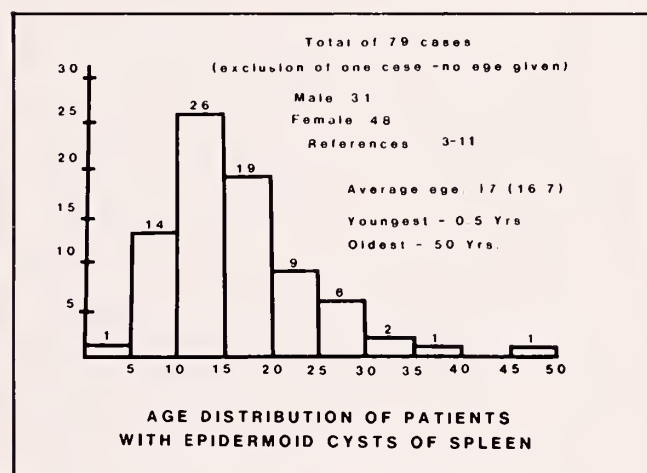


Fig. 4. — A. X50; B. X100; Section of cyst showing squamous cell lined wall (arrows) with broad fibrous tissue beneath the lining epithelium. Insert on the upper portion of B is X400, showing squamous cells lining the cyst wall.



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Nurse practitioners: a national perspective

Barbara L. Nichols, M.S., R.N.

During the past 15 years, multiple social forces served as the impetus for the introduction of and support for the concept of nurse practitioners. Initial goals were increased access to care, provision of health maintenance and prevention of illness at less cost, and increase of nurses' skills, especially in the area of health appraisal. The traditional nursing role was expected to be maintained and improved by the addition of these new capabilities. As a result of these changes, both nurses and physicians have explored the mix between the *interdependence* of both nurses and physicians in the provision of health care services and the *independence* of nurses in the provision of nursing care services and the independence of physicians in the provision of medical care services.

There is, of course, nothing new in the concept of nurses and physicians working together; they have been doing so for more than 100 years. Likewise, there is nothing new in the concept of nurses and physicians working independently of each other, as they have also been doing that for almost a century. Lillian Wald's Henry Street Settlement was established in 1895, and Margaret Sanger's birth control clinic, in 1916. These are two well-known examples of nurses practicing nursing without a direct relationship with a physician.

Registered nurses provide direct care to patients utilizing the nursing process. They work in a collegial and collaborative relationship with other health professionals to determine health care needs, and they assume responsibility for nursing care. In the course of their nursing practice, they assess the effectiveness of actions taken, identify and carry out systematic investigations of clinical problems, and engage in periodic review of their own contributions to health care and those of their professional peers.

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Development of Nurse Practitioner Concept

• Let us examine, from an analytical perspective, the concept of nurse practitioners as it developed nationally and in the State of Florida. The role of the nurse practitioner was first demonstrated at the University of Colorado in 1965. A special educational program prepared registered nurses to obtain and record a health and medical history, to perform a physical examination, and to manage minor childhood diseases under the supervision of a pediatrician. The intent of the first nurse practitioner demonstration project was to determine the safety, efficacy, and quality of a new mode of nursing practice designed to improve health care to children and families and to develop a new nursing role — that of the pediatric nurse practitioner.¹ A similar program was established at the University of Kansas Medical Center, directed toward nurse management of adult patients with chronic illness.²

Nursing is a problem-solving, decision-making process, not a role or a series of competencies or tasks attributed to a title.

The initial goal in the first nurse practitioner project was to prepare nurses on the master's level for expert practice, teaching and clinical research; however, the societal demands for health care services changed that goal. Short-term, continuing education programs to prepare nurse practitioners were funded by the federal government and others. The success of these projects encouraged the development of others, and soon there were programs for family nurse practitioners, school nurse practitioners, adult nurse practitioners, and maternal nurse practitioners, among others.

The social climate of the late 1960's and the early 1970's focused on the need to provide increased access to needed health services for all citizens. In his health message of 1971, the President of the United

States noted the significant contribution that specialized nurse practitioners could make in extending health services. The Secretary of Health, Education, and Welfare (now Health and Human Services) emphasized federal support for this concept and convened a committee to study extended roles for nurses. The committee report, "Extending the Scope of Nursing Practice," was published in 1971.³

Numerous studies have reported on the utilization, evaluation, and patient acceptance of nurse practitioners. The studies revealed that patients accepted care by nurse practitioners very well^{4,5,6} and that utilization of nurse practitioners led to increased physician productivity⁷ or gained time that could be used by physicians for other purposes.^{8,9}

The critical issue, however, was whether the care provided by nurse practitioners was safe, adequate, and/or of sufficient quality to ensure good patient care. In a one-year study comparing the performance of nurse clinicians under staff physician supervision and the performance of interns and residents under the same supervision, Bessman¹⁰ reported no differences in the quality of care between the physician house staff system and the nurse clinician program as measured by specific biomedical parameters, morbidity and mortality.

To remain viable, primary health care nursing must be complementary and additive to medical care, not a substitute.

Similar results were obtained by Sackett, et al.,¹¹ comparing nurse practitioner care with family physician care. In that study, the close comparability of mortality rates and physical, social, and emotional function between the two groups supported the conclusion that patients randomly assigned to receive first-contact, primary care from a nurse practitioner enjoyed favorable health outcomes as compared to patients receiving conventional care.

Further validation was provided by Komaroff, et al.,¹² and Gorden¹³ who studied both the care provided by nurse clinicians, and that given a control group by attending physicians in a clinic on a time appointment basis. Their studies revealed that among the patients of the nurse clinicians there were fewer lapses in care, proportionately fewer patients whose health conditions were rated as unstable one year after their initial visit, and none whose health condition was judged as deteriorated.

Hastings, Vick, et al.,¹⁴ reported on the introduction of six primary care nurse practitioners into a large jail health service in Dade County. The system's primary care volume capacity doubled, the average

cost of each patient visit decreased by about one third, and the technical quality of primary care improved continuously during a three-year period while patient outcomes, patient satisfaction levels, and overall mortality rates remained unchanged.

Florida first considered the concept of nurse practitioners in 1973, when Representative Gwen Cherry introduced H.B. 2416, which created a category of "advanced registered nurse practitioners" who had specialized preparation in an area of nursing and which allowed them to have in their possession prescription drugs for emergency use.

Nurses often have a more holistic, general psychosocial orientation, in contrast to the traditionally pathophysiological focus of physicians, as specified by medical diagnoses.

At the urging of the medical and nursing communities, further work on the bill was postponed pending a total revision of the nursing practice act. A task force established in 1974 drew from the "Criteria for Joint Position Statements on Practice" (adopted by the Florida Medical Association and the Florida Nurses Association) and also from a "Statement on the Scope of Nursing Practice" (adopted by the Florida State Board of Nursing) to develop a nursing practice act that incorporated the concept of nurse practitioners. Successful passage of H.B. 1829 in 1975 ratified the legislative commitment to the nurse practitioner concept. The title used in the legislation is "advanced registered nurse practitioner."¹⁵

Definitions of Nurse Care • Terms to describe nurses who give care to patients have proliferated in the past several years. Such proliferation can be related to advancements in nursing theory and in technology, as well as the desire of nurses to identify more specifically the scope of their practice. Rather than clarifying nursing practice, however, these terms and definitions have tended to confuse the levels of practice within the nursing profession as well as to confuse consumers and other professionals.

In Florida, as in other states, attempts to further clarify the issues through legislation have frequently resulted in only more confusion. Lists of proposed functions and activities perhaps appropriate in certain practice settings cannot be applied in general to all settings. The nurse practitioner concept is not one specific role. Rather, it is a composite of a variety of roles, each one composed of both basic and advanced independent nursing functions and interdependent delegated medical functions.

Several illustrations emphasize this point. One is that of the nurse anesthetist. This practitioner is very familiar to most physicians. The nurse anesthetist is clearly performing an interdependent, delegated medical function when administering anesthesia in the operating room under the general supervision of the chief of anesthesiology. On the other hand, in pre-operative teaching about effects of anesthesia or post-operative counsel on breathing exercises, the nurse anesthetist is performing an independent nursing function. However, when the nurse anesthetist functions in the delivery room, such delineations become hazy. Is the source of the interdependent delegated medical function the distant anesthesiologist or the delivering obstetrician who has no expertise in the administration of anesthesia? What if the delivery is being performed by a nurse-midwife and not by a physician?

A second example is the clinical specialist in psychiatric and mental health nursing, who is recognized as an advanced registered nurse practitioner in Florida. This practitioner may not be familiar to most physicians. The clinical specialist is prepared at the master's or doctoral level in nursing and functions primarily in an independent advanced nursing role, providing intensive psychotherapy to individuals, families, and groups. Only occasionally will this nurse refer clients to a consulting physician or psychiatrist for prescription of appropriate medication or admission into protective or residential treatment.

The increased use of geriatric nurse practitioners has been a key to improving the quality of care in nursing homes.

Yet another illustration is that of the geriatric nurse practitioner. This nurse may function as an expert practitioner, clinical teacher, consultant, and/or change agent. Her activities may include giving direct care to patients, conferring with families, teaching the nursing staff, planning and evaluating care, managing medications, and utilizing appropriate resources. The increased use of geriatric nurse practitioners has been a key to improving the quality of care in nursing homes. As one geriatric nurse practitioner commented, "What I do is separate from medicine; I practice nursing. When I'm dealing with patients, I deal with health and health behaviors. I recognize myself as accountable to the patient, his family and myself. When I feel that other professional consultations (medical, dietary, occupational therapy, dental) are needed, I tell the patient, who then decides whether to get the consultation."¹⁶

Although these roles — the nurse anesthetist, the clinical specialist in psychiatric and mental

health nursing, and the geriatric nurse practitioner — as illustrated are quite different, in Florida as in some other states, each is recognized as an advanced registered nurse practitioner.

Primary Health Care • Many nurse practitioners provide primary health care services. In 1971, primary care was defined as (a) a person's first contact in any given episode of illness with the health care system that leads to a decision of what must be done to help resolve his problem; and (b) the responsibility for the continuum of care, i.e. maintenance of health, evaluation and management of symptoms, and appropriate referrals.¹⁷

The primary health care services that nurse practitioners provide include the following: (1) assessment of real and potential health hazards and current health status; (2) sound clinical judgments based on assessment of physical, psychological, emotional, spiritual, social, and environmental needs of the client; (3) analysis of health behavior related to personality, lifestyle, and culture; (4) teaching, counseling, and assisting individuals and families to assume responsibility for the prevention of illness and the promotion, maintenance, and restoration of health; (5) development, implementation, and periodic evaluation of therapeutic plans to promote satisfactory patient outcomes; (6) consultation, referral, and collaboration with other health care disciplines involved in the delivery of total patient care; (7) design, implementation, participation in, and evaluation of research activities in primary care; (8) leadership as change agents in exploring nontraditional methods of delivery of care so as to promote more comprehensive patient care while maintaining safe, high-quality, accessible health care.¹⁸

As a means of demonstrating accountability, the primary health care nurse practitioner contributes to and participates in the evaluation of services given, utilizes the standards of nursing practice, engages in peer review, acquires certification, participates in continuing education to maintain knowledge and skills required to function competently, and encourages the active participation of patients in attaining individual optimum levels of wellness.

To remain viable, primary health care nursing must be complementary and additive to medical care, not a substitute. The public must be informed of the distinctive contribution of nurses, and nurses must take pride in that distinctiveness. Health promotion, education for health self-care, and the optimal functioning of human beings are at the core of nursing. Just as the *content* of their respective practice differs, the *style* of practice of nurses and physicians differs. Nurses often have a more holistic, general psychosocial orientation, in contrast to the traditionally pathophysiological focus of physicians, as specified by medical diagnoses.

Nursing is a problem-solving, decision-making process, not a role or a series of competencies or tasks attributed to a title. It is often the case that some tasks can be performed by more than one group of professionals. Further, a task that has been exclusively under one professional domain can readily become the responsibility of others as knowledge and use concerning it expands. There are many examples of this in health care. It is the basic nursing process that has been unrecognized and undervalued, and now urgently needs to be articulated. The future of nurses as providers of health care depends upon it.¹⁹

The ANA View • The American Nurses' Association considers nursing a practice discipline interested not in the diagnosis and treatment of disease, but rather in providing nursing care related to human responses to actual or potential health problems. ANA supports full utilization of nurses' knowledge and skills in acute care, in the management of chronic disease, and in the maintenance of health. ANA recognizes that nurses in practice are now providing a set of patient care services that reflect a blend of some of the diagnostic and management skills that were previously, traditionally, and publicly reserved to physicians. However, the American Nurses' Association asserts that these practitioners are first of all nurses — performers of a set of skills related to those patient responses that achieve desired outcomes of health care. The American Nurses' Association does not consider the nurse practitioner or other nurses functioning in independent settings as substitutes for physicians, and does not view such activities as being outside the scope of nursing.²⁰

Expanded Roles vs. Extended Roles • Two terms have been used, sometimes interchangeably and often erroneously, in regard to the scope of nursing practice in the last decade: *expanded roles* and *extended roles*. In 1981, in *Nursing: A Social Policy Statement*,²¹ the American Nurses' Association implied that "expanded role" means new additions to nursing practice that expand its boundary outward into new, heretofore uncharted territory but related to its recognized domain. Clinical specialists in nursing, for example, work in expanded roles. The term "extended role," on the other hand, means that the practice of nurses merges into or overlaps the work of some other profession. Physical assessment, when it was first taught to nurses by physicians, constituted an extended role. Nurses soon recognized the importance of adding systematic, comprehensive, physical assessments to their already well-developed psychosocial assessment skills. As practiced now by most nurses, assessment is a nursing activity to aid in data collection in order to plan for management of patient

care. In much earlier days, taking a blood pressure reading was a physician activity, then an extended role of nurses, and now a routine nursing activity. There are few activities in the health care field that are not shared by more than one profession. What tends to remain constant is the phenomenological focus for the practice of the profession.²²

Accompanying changes in practice have been corresponding changes in education. Continuing education programs for nurse practitioners served as testing grounds for curriculum and as forerunners for clinical practice in a variety of settings;²³ baccalaureate nursing programs began to incorporate these concepts into their basic curriculum. Baccalaureate nursing students are learning to develop a comprehensive data base, to make judgments on the physical and psychosocial status of patients, to record their findings, and to use these to develop and to implement nursing care plans to the level of their scientific preparation and stage of professional development. Graduate nursing students learn a specialty practice with management of care and leadership for other persons providing nursing care. They learn to direct and implement health services, interpret research findings, and consult with colleagues and consumers.

The challenge for nurses and physicians is to look to the future and to plan together for a rational system of health care delivery that will allow each profession to provide its unique functions to the consuming public.

The challenge for nurses and physicians is to look to the future and to plan together for a rational system of health care delivery that will allow each profession to provide its unique functions to the consuming public. The intersections — interprofessional and intraprofessional — are fluid, shifting, changing, and they will never be otherwise. On the other hand, the core, the focus, and the phenomena to be diagnosed and treated tend to be more stable and unchanging, and they need to be better understood and articulated.²⁴

That human beings, whether healthy or ill, need nurses and physicians and their services can scarcely be denied. Both types of practitioners are needed in varying numbers and proportions. Utilizing each discipline to its fullest potential, while recognizing the differences as well as interdependence, will pave the way toward the mutual objective of both nurses and physicians: improved patient care.

Acknowledgements

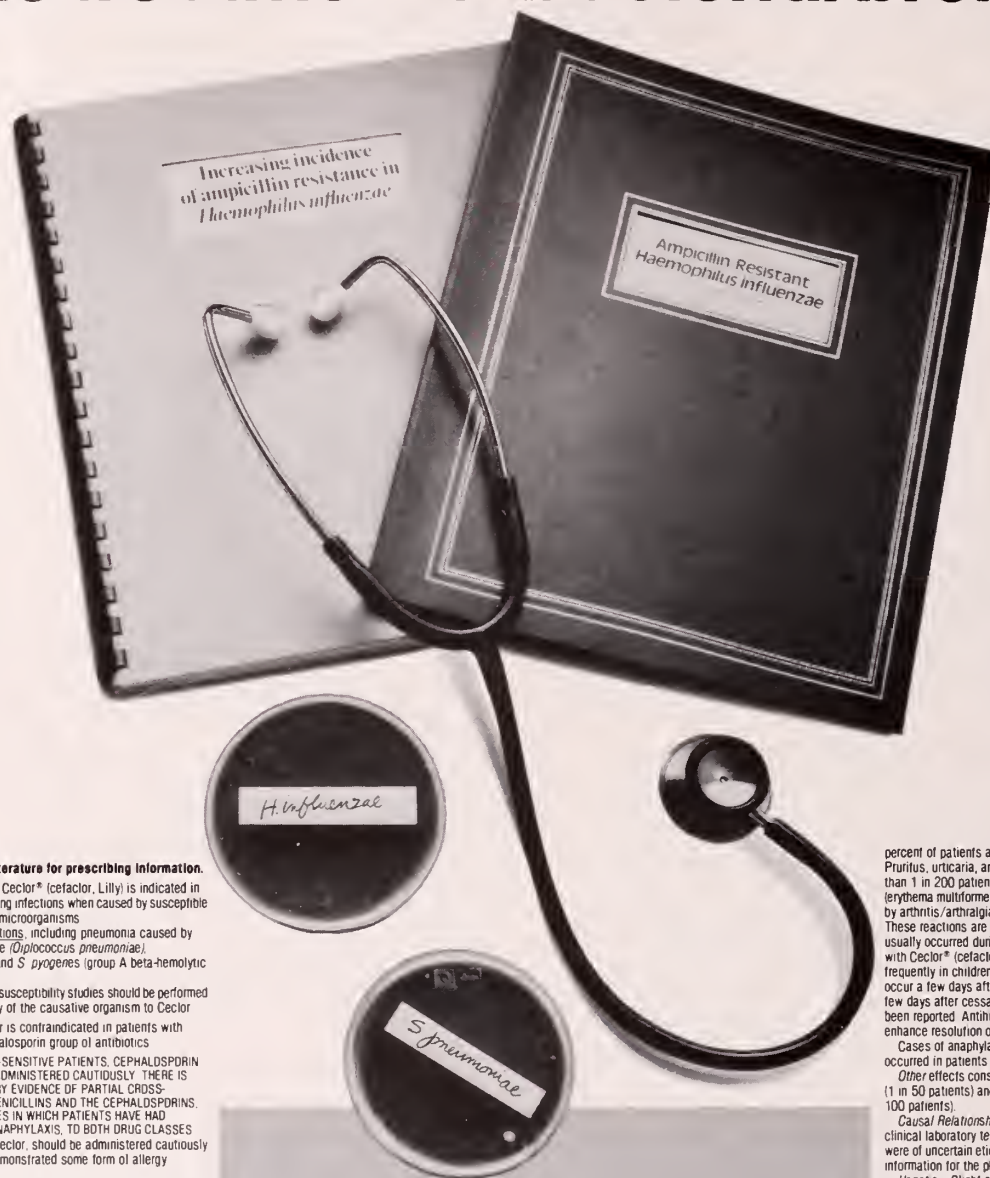
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An added complication... in the treatment of bacterial bronchitis*



Brief Summary

Consult the package literature for prescribing information.

Indications and Usage. Cefclor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or anti-fertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefclor.

Hypersensitivity reactions have been reported in about 1.5

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

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percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefclor® (cefclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). (1002218)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.⁸

Note: Cefclor is contraindicated in patients with known allergy to the cephalosporins, and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

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FLORIDA MEDICAL

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NOTES & NEWS

Diagnosis and treatment of Reye's syndrome

Summary of NIH consensus conference statement

A National Institutes of Health Consensus Development Conference on the Diagnosis and Treatment of Reye's Syndrome was held at NIH March 2-4, 1981. The conference was sponsored by the National Institute of Neurological and Communicative Disorders and Stroke and was co-sponsored by several other NIH Institutes. The Centers for Disease Control and the National Center for Health Statistics collaborated on the meeting and further assistance was provided by the Office for Medical Applications of Research, NIH.

At NIH, Consensus Conferences bring together biomedical investigators, practicing physicians, consumers, and others to provide a scientific evaluation of a drug, device or procedure and attempt to reach agreement on its safety and effectiveness. After hearing formal presentations at the Reye's conference, a Consensus Development Panel issued a statement of consensus. Following is a summary of that document:

It is important that there be wide distribution of information concerning Reye's syndrome. Parents should learn the signs of this disorder and seek prompt medical attention for their children if symptoms develop. Parents should suspect Reye's Syndrome if their children unexpectedly develop repetitive vomiting and altered behavior such as lethargy, confusion, irritability, or aggressiveness during or while recovering from a viral illness (most commonly chicken pox or influenza). Early diagnosis and intensive pediatric care by an experienced medical team are key factors in improving the survival rate of affected children.

With regard to the possible relationship between Reye's and the use of salicylates such as aspirin to reduce fever, physicians and parents should "be aware that most, if not all, medications have potential deleterious effects; thus, caution in the use of salicylates in children with influenza and those with varicella is prudent." More data are necessary, however, before recommending changes in the way physicians treat fever in children.

Administration of dextrose-containing fluids is standard therapy for early stages of Reye's syndrome, but several methods used to control cranial pressure frequently found in the later stages must still be considered investigational. Use of intracranial pressure monitoring devices has not been shown to have a detrimental effect on outcome in children with Reye's.

While complete recovery from the disorder can be expected in the majority of cases, possible psychological aftereffects may be seen in some children who experience the more severe stages of the disease.

Several research areas deserve greater attention in the future: the cause of the illness (the most critical concern), epidemiology, diagnosis, and disease screening. Treatment, monitoring, evaluation, and followup of patients also should be explored.

Copies of the full Consensus Statement may be obtained from Michael J. Bernstein, Office for Medical Applications of Research, Building 1, Room 216, National Institutes of Health, Bethesda, MD 20205. A bibliography on Reye's syndrome also is available from this office.

Harvard is prolific breeder of medical school deans

Harvard Medical School is the principal mother lode for the production of medical school deans in the United States, according to two medical educators.

Almost 11 percent of the deans heading medical schools from 1960 to 1980 were Harvard graduates. Harvard and 14 others of the nation's 126 medical schools supplied more than half the deans during that period. The other schools were identified as Pennsylvania, Cornell, Northwestern, Michigan, Johns Hopkins, Minnesota, Illinois, Chicago (Pritzker), Columbia, Yale, Rochester, N.Y., Washington (St. Louis), Maryland, and New York (NYU).

The facts were cited by Robert G. Petersdorf, M.D., Dean of the School of Medicine, University of California, San Diego in La Jolla, Calif., and Marjorie P. Wilson, M.D., Senior Associate Dean at the University of Maryland School of Medicine, in an article in a

recent issue of *The Journal of the American Medical Association*.

Drs. Petersdorf and Wilson found that deans are most likely to be drawn from the field of internal medicine, with pathology, pediatrics and surgery also producing more than an average share. Deans typically are 47 or 48 years old when appointed and they hold their jobs from 4.1 to 5.6 years.

UF college of medicine gets new scholarship funds

A gift from an Ocala couple has made possible the establishment of a new scholarship fund for deserving and needy students at the University of Florida College of Medicine.

William B. Deal, M.D., Dean of the College, accepted the first in a series of contributions from the estate of the late William Warren Wolff and from his widow, Mrs. Marie C. Wolff of Ocala. The amount of the gift was not announced, but it will be managed by the University of Florida Foundation.

"This gift could not have come at a time when it is more needed and more earnestly appreciated, in light of severe curtailment of federal loans and other sources of financial support for medical students," Dr. Deal said.

Dr. Norman Block is appointed to UM endowed chair

Norman L. Block, M.D., has been appointed to a \$1 million endowed faculty chair in urological oncology research at the University of Miami School of Medicine.

The professorship was made possible through a gift from an anonymous donor/patient of the UM Department of Urology. Dr. Block is an Associate Professor of Urology, Oncology and Biomedical Engineering at the School.



WORTH REPEATING

Why bother with politics?

In every society there are a few hard core political activists, a few members who feel vaguely guilty about not being more active, and a large number who are either disinterested or downright antagonistic to the world of politics. It is a common presumption that the world of politics is enemy territory and that attempts to influence it are akin to Don Quixote's well known attacks on the windmill. Many have accepted a view of government as "big brother" and have

thereby given up the chance to change things by default. Some have argued that attempts to influence government through such organizations as FLAM-PAC and AMPAC amounts to stooping to "their" level or playing "their" game. Organized medicine through such groups as the AMA are viewed as just a medical brand of politics, no more responsive to — or representative of — the average doctor than government itself. Those who feel this way often respond to pleas for more political involvement with the question "Why bother?" The question implies the answer: "There's really no use trying." Those who have been active and who have made the effort to stay informed know that this implied answer is wrong — it is not only worthwhile to try, it can be very effective.

Doctors tend to be no better or worse than other groups of people in this country in terms of their cynicism and distrust of others. We understand other doctors and therefore tend to trust one another for the most part. We like to believe that when the average doctor makes a mistake it is not because he lacks the desire to do the right thing, but only because of some lack of appropriate information, understandable gap in his knowledge, or difficulty imposed by other forces with which he was trying to contend. It really should come as no great shock to us to learn that politicians are also mostly intelligent, educated, decent human beings. Most of them approach their jobs with the same desire to do the right thing as a doctor, and when they make mistakes it is for the same reasons. We like to think of our jobs as being more difficult because we so often deal with matters of life and death. In fact our job is in some ways simpler. When we make a difficult decision it generally is a question of what is good or bad for an individual. The politician is constantly having to decide what is best overall, knowing that his decision will almost always be bad for someone. When the politician makes a mistake because he did not know the appropriate medical facts or had not received the information doctors could have supplied, then we can hardly blame the politician — the blame falls squarely on every doctor who could have provided that information.

On a local level, this responsibility usually occurs on a very personal basis. If a friend in local government were considering a matter that was of great importance to us, we would certainly see that he knew our side of the issue and understood its significance to us. On the state and national level, we would no doubt respond in the same manner if a close friend were involved in the decision being made — and if we had kept up with his activities closely enough to know he was involved. Unfortunately, it is nearly impossible to keep up with the activities of even a close friend when he is away in Tallahassee or Washington, and even when we do seek to influence him, there is little effect unless others like us are also seeking out their friends among his colleagues.

That is where the organized political action committees and medical associations come into the picture. Sometimes we would not even recognize the importance of an issue if its implications were not uncovered for us by the on-the-scene experts representing organized medicine. Rarely would we know the appropriate time to seek the ear of our elected officials in order to have some influence on their decision if not warned by those experts. Never would our efforts have the impact of a statewide campaign unless coordinated by those experts. If we are to influence the political system, then we are absolutely required to have a system of our own for dealing with it.

But why should we bother to influence the system? I think there are a number of reasons:

1. Our patient's lives and health can be adversely affected by bad political decisions. As physicians we certainly have some responsibility for the health of society as a whole as well as for that of our individual patients. Florida has become a happy hunting ground for Laetrile and DMSO pushers because the legislators did not understand the potential dangers involved. Now Optometrists want to prescribe medicines and Chiropractors want guaranteed use of hospital services. If we feel such changes are not in the public's interest, then we had better bother to be involved.
2. Our livelihood can certainly be adversely affected by political decisions. Public payments for health care, insurance regulation, hospital and pharmacy regulation, and even small business regulation directly affect our ability to both treat patients and make a living at it.
3. Our position in society demands some leadership on our part in influencing the political process. We are among the most highly educated members of society and are also among the most richly rewarded, both in terms of income and in terms of respect from our fellow citizens. It is considered old fashioned to talk in terms of *noblesse oblige* these days, but the idea still rings true. There are doctors in some parts of the world that drive taxicabs at night to supplement their income. Certainly our status in this country demands some added responsibility to help make the political process work for everybody.

Both individually and as a group, doctors cannot afford to ignore politics. Individually we can hope for very little impact on the course of political decision making on the state or national level, but as a group the impact can be great. If you care about your opinion being heard, you had better join the group!

Henry L. Harrell Jr., M.D.
Ocala

Reprinted from *The Bulletin of the Marion County Medical Society*, March 1981.

Informal hearing is same as guilty plea

You have many rights that protect your DPR license, but they are useless unless you know and use them.

DPR law is complicated and can entangle you in its web — sometimes mistakenly. There is, perhaps, no other area of law with more legal protections, but which are easier to lose.

As unlikely as it may seem, a client, patient or customer to whom a long time ago you provided services, may be unhappy with you and complain to DPR.

DPR has the duty by law to follow up on each complaint, investigate and prosecute you if the complaint seems well founded to DPR. A complaint may seem well founded to DPR (sitting hundreds of miles from you) but may look unfounded to you. That is because you see the complaint from your side of the fence and DPR sees it from its side of the fence.

DPR's job is to prosecute — like a state attorney. DPR views complaints through prosecutor's eyes. DPR is your prosecutorial adversary the moment a complaint is filed against you. DPR is just doing its job, which is a difficult job.

This is when your rights can and will protect you.

Following is a brief summary of some of your rights that can protect you if you use them.

You have the right to remain silent and not talk to any DPR investigator or lawyer. This right to remain silent extends to your right not to give or produce to DPR your business/office records, under many circumstances. Anything you tell or give to DPR during an investigation or prosecution can and will be used against you.

DPR law guarantees, under most circumstances, your right to know of the substance of charges against you during the investigative stage.

Unless DPR properly informs you of the substance of the complaint against you, you should not discuss your side of the story or give DPR investigators any records or statements. DPR may be investigating you for one thing and you may think the complaint is another thing and your explanation to DPR may only confuse DPR into thinking you're guilty, justifying prosecution. This is why you must know the substance of the charges against you before you talk to DPR.

You have the right to obtain all of DPR's investigative files against you, if probable cause is found to prosecute you for violation of your licensing statute. But it's important to remember, most of the time, you don't have to give DPR anything.

In other words, you can learn everything from DPR without revealing what you have.

You have the right to consult an attorney before you talk to or give DPR anything. You also have the

right to have an attorney with you anytime you talk to or appear before DPR or your licensing board.

It is dangerous to deal with a prosecutor or appear before your board without an attorney. The old adage is true: "A lawyer who represents himself, has a fool for a client."

You have the right to a hearing before an independent hearing officer on any charges against you. This is the only way to dispute the charges.

You waive your right to dispute the charges if you ask or elect to explain your story to your licensing board instead of asking for a hearing before a hearing officer. In other words, if you elect to go before the Board instead of a hearing officer, you automatically plead guilty and the only thing left for the board is to decide what penalty to impose on you.

You have the right to appeal to the courts any penalty imposed on your license. However, your chances on appeal may depend on what rights you gave away during the investigation, prosecution and hearing.

DPR law is complicated. It involves many steps. You may inadvertently get caught in it and suffer needlessly — unless you exercise your rights.

*Paul Watson Lambert
Slepin, Slepin, Lambert
Wass, Tallahassee*

Editor's Note: Mr. Lambert is former counsel to DPR and several licensing boards and former DPR prosecutor.

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The complete physician

Remember when practicing medicine was fun?

Remember when there was that keen excitement, that uplifted feeling of making the correct diagnosis, edging out the attending physician or recognizing the unusual presentation of illness? Remember when we were all complete physicians?

The practice of medicine has become progressively complex. Wealth of knowledge doubles every few years and one can easily recognize why it is impossible to keep up with all fields of medicine and be expert in every area. We live in an age of medical specialization where each of us is turned on to "doing our own thing." Obviously, there's a lot to be said for this brand of medicine wherein each of us has our own little niche of expertise. It is more comfortable for the physician to try to keep abreast of all developments in his field and it is similarly comforting to the patient to know that they are being cared for by one who is expert for their particular illness.

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Although I am a proponent of specialty medical care and the consultative approach to evaluation of diagnostic problems, something is lacking. It does not happen often, but I am sure we are all aware of individual cases where specialty illness was diagnosed and treated correctly only to miss a concurrent problem of perhaps equal significance and import that was out of the specialty area of the attending physician. We have become so involved in our own specialty that we perhaps do not take the necessary time to view the patient over all. Obtaining a PAP smear should be as much a part of a urologic evaluation as it is for a routine physical examination in the gynecologist's office. Preparing the patient for cataract surgery does not obviate the need for auscultation of the heart.

Why are we perhaps falling into the subspecialty trap? Are we so busy caring for a large volume of patients that we don't have the time? Is it perhaps the loss of ability to perform these various tests of physical examination because we're out of practice? Is it perhaps our assumption that the patient's "other" physician will follow up on that aspect of care? Unfortunately, patients are also falling into the sub-specialty trap. Where they requested that their personal physician be responsible for their entire care in the past, a patient may now have as many as half-dozen physicians caring for each subspecialty area, each assuming that the other is taking responsibility for the patient as a whole.

Paying attention to detail and firming up a tentative diagnosis are only some of the qualities of a complete physician. We should not lose sight of the fact that specialization has its pitfalls. Taking a little more time to evaluate the patient fully, may be just the prescription that the doctor ordered.

Remember when practicing medicine was fun?

*Stephen R. Zellner, M.D.
Fort Myers*

Reprinted from *The Lee County Medical Society Bulletin*.



CORRESPONDENCE

In support of PSRO

Editor's Note: In the January Issue of *The Journal*, Edward Pedero, M.D., Tampa, wrote an editorial on "The Financial Charade of Home Health Care". Edward J. Rupnik, M.D., wrote the following letter to Dr. Pedrero upon reading this editorial.

I read, with considerable interest, your editorial, "The Financial Charade of Home Health Care", in the January, 1982 issue of the JFMA. I must say that I am

totally in agreement with your observations and comments.

Regrettably, the Reagan Administration does not share our concerns. I have enclosed a copy of our efforts at Home Health Care Review which, I felt, might be of interest to you. Unfortunately, although the program proved to be cost-effective, the Administration denied further funding.

I would hope that in their efforts to reduce Federal regulation of the medical profession, the leadership of the FMA would take another hard look at the PSRO program (either in its present format or under the Durenberger proposal) before a decision is made to continue their official anti-PSRO stand.

*Edward J. Rupnik, M.D.
Executive Medical Director
West Central Florida
Professional Standards Review
Organization, Inc.
Sarasota*

Medicaid prescription update

To the Editor: It might be useful for the members of the Florida Medical Association to be aware of the fact that, effective December 1, 1981, no Medicaid prescriptions for non-steroidal, anti-inflammatory drugs, will be filled if the physician does not write "medically necessary" on the prescription. This must be in the physician's own handwriting. The reason given for this is that the non-steroidal anti-inflammatory drugs (such as Motrin, Tolactin, Naprosyn, Indocin, etc.) are thought by many to be no more effective than therapeutic doses of salicylates (eighty grains daily). There is however, a great deal of controversy regarding comparative toxicity.

In order to encourage increased use of salicylates, the Medicaid program is now reimbursing for salicylates if this is written by prescription.

*Charles B. Kahn, M.D., President
Florida Society of Rheumatology
Hollywood*



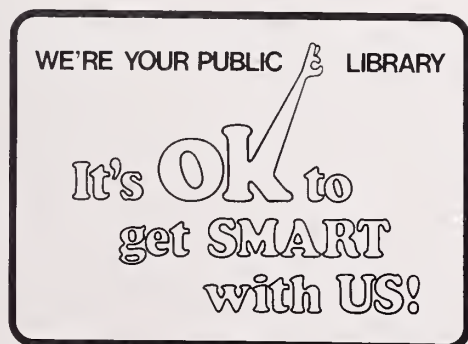
ETC.

Summary of counter-suit Wallace vs. Gill

(Editor's Note: The following summary of a counter-malpractice suit of interest was submitted for publication in *The Journal* by T. Byron Thames, M.D., Chairman of the FMA Committee on Professional Liability).

This case involved a physician who was a neurologist accused by plaintiff's attorney of having treated a patient in November 1974, whom the doctor had not seen or treated in any manner. After three and one-half years of depositions and interrogatories, etc., the doctor was dismissed from the suit on the morning of the trial, April 5, 1978. A malpractice counter-suit was filed in the spring of 1979 and in late fall of 1981, a summary court judgement for the defendant's attorney was denied. The case went to trial January of 1982, and the judge granted the defendant attorney's plea for a directed verdict. Despite the loss of the suit, the physician feels a physician may have a successful countersuit. The law requires a lawyer to have a reasonable investigation prior to filing a malpractice suit against a doctor if it can be shown that the attorney did not actually carry out a reasonable investigation, a possible successful countersuit could be established. This could establish case law which then could be helpful in further countersuits.

Full information has been sent by the original physician to the county medical societies, and if you feel that you have a source of action against an attorney for being falsely named, you may discuss the facts of the case with your local county society for further information.





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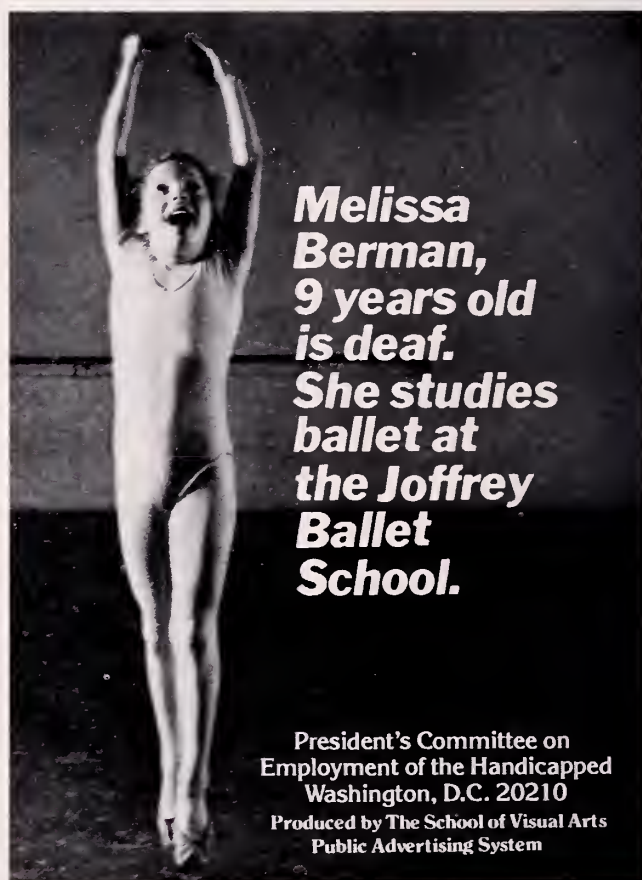
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namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

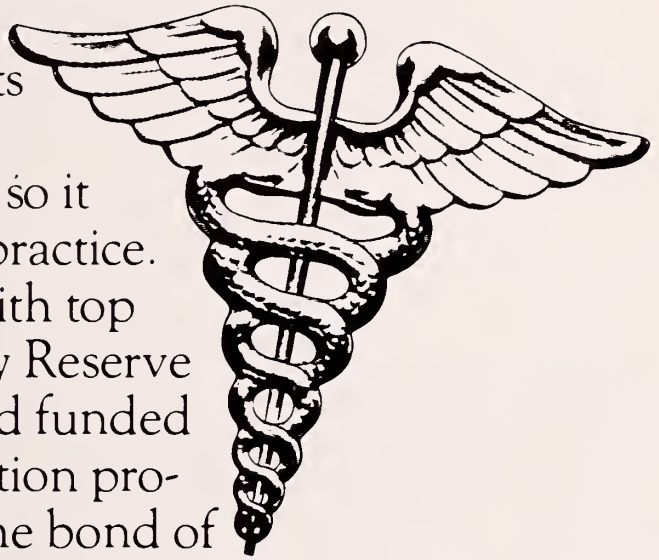
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Facelifts — everything you always wanted to know

By Norma Lee Browning, 224 Pages. Price \$14.95.
Doubleday and Company, Inc., New York, 1982.

Norma Lee Browning has written a most informative book on cosmetic surgery of the face for the lay person who is contemplating having this kind of work done. She offers, obviously after extensive research, her advice on how to choose a surgeon as well as advice on how to choose between having a face lift and a chemical peel. She is relatively objective about deciding whether to have a lift or a peel, favoring neither one procedure over the other, but rather presenting the pros and cons of each.

The last two chapters of the book deal with how to select a doctor once the decision to do something is made. I must say I found her advice sound and helpful and, indeed, more so than in any other book I have ever read on the subject.

I find, however, her gratuitous attacks on M.D.'s in general, cosmetic surgeons in particular, and organized medicine to be offensive and in error in many instances. She states at one point "but I doubt if the whole kit and kaboodle of Hippocratic M.D.'s — shouldn't that be spelled hypocritic? have spent a tenth as much time and effort checking out the lay operators as we have". This kind of mass condemnation robs the book of some of the worth that is really there.

There is also some inconsistency in that she apparently has spent a great deal of time in some areas of research, e.g., the history of chemical skin peeling, while in others she has been sadly lax. An example of the latter is in her extolling the attributes of some operators — M.D. and lay alike — who are known to be unethical and, in certain instances, even criminal in their practices.

All in all, it's an entertaining book with a flavor of its own and definitely should be read by anyone having anything to do with cosmetic surgery, patient and doctor alike.

Howard L. Gordon, M.D.

- Dr. Gordon is in the private practice of plastic surgery in Miami and is Assistant Clinical Professor of Surgery (Plastic), at the University of Miami School of Medicine.

Something hidden

By Jefferson Lewis. 311 Pages. Price \$17.95. Doubleday and Company, Inc., New York, 1982.

Something Hidden is an excellent biography of one of neurosurgery's great scientific pioneers, Wilder Penfield. The author, Jefferson Lewis, is not only an accomplished writer, he is also one of Penfield's grandsons. Undoubtedly, this personal element has added to the quality of the book. Lewis, with his eminently readable style, has traced the life of his grandfather. From childhood in Spokane, Washington through undergraduate years at Princeton, and on to a Rhodes scholarship, one is presented with a portrait of an unusually gifted and highly motivated man. The story of the Montreal Neurological Institute — its establishment and subsequent rise to a world renowned center for neurosurgical research and treatment — is of great interest.

Penfield, not unlike other famous neuroscientists, became increasingly concerned with the essentially philosophical issue of mind versus body. He knew from his multitude of intraoperative experiences, that patients readily distinguished between actions he induced with electrical stimulation and actions which were a product of their own volition. Accordingly, he steadfastly refused to believe that the human mind could be ultimately reduced to scientific mechanisms. To borrow the phrase of his opponents, he believed that there was a "ghost in the machine."

If we have any criticism of this book, it is only that Lewis has emphasized the mind-body issue at the expense of Penfield's truly great scientific achievements. These include remarkable advances in cerebral localization, EEG technology, and the surgical treatment of epilepsy.

In conclusion, we wholeheartedly recommend this book. In the saga of Wilder Penfield, a great surgeon-scientist and a man of faith, the reader may take comfort in the fact that he struggled so well with the great issues of life which trouble us all. Of a biography, and of a man, one may ask no more.

William A. Friedman, M.D., and
Albert L. Rhoton Jr., M.D.

- Dr. Friedman is currently Chief Resident in the Department of Neurological Surgery; and Dr. Rhoton is R.D. Keene Family Professor and Chairman of the Department of Neurological Surgery, College of Medicine, University of Florida, Gainesville.

Physician's handbook

By Marcus A. Krupp, Lawrence M. Tierney Jr., Ernest Jawetz, Robert L. Roe, Carlos A. Camargo, Editors. 775 Pages. Price \$12.00. Lange Medical Publications, Los Altos, California, 1982.

This is the 20th edition of *Physician's Handbook* first started in 1941. In contrast to most books of this type, the editors have resisted expanding to the larger format. This book may still be carried in the lab coat pocket. It will continue to have its usefulness for medical students, physicians in training and other medical personnel. This edition maintains the previous high quality.

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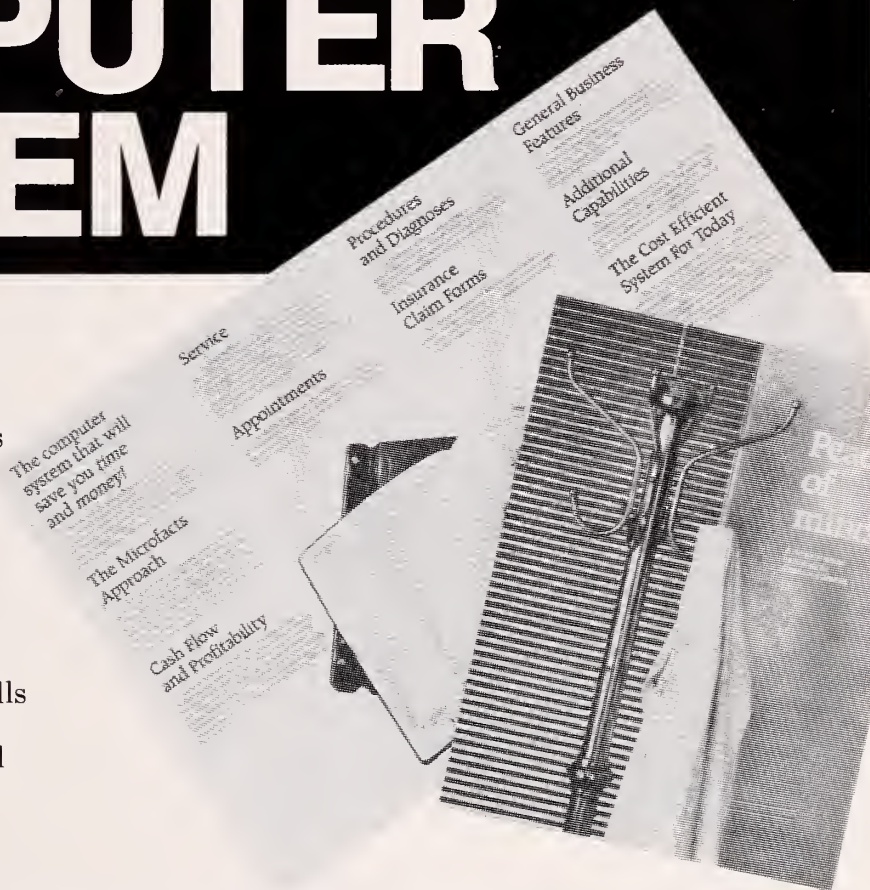
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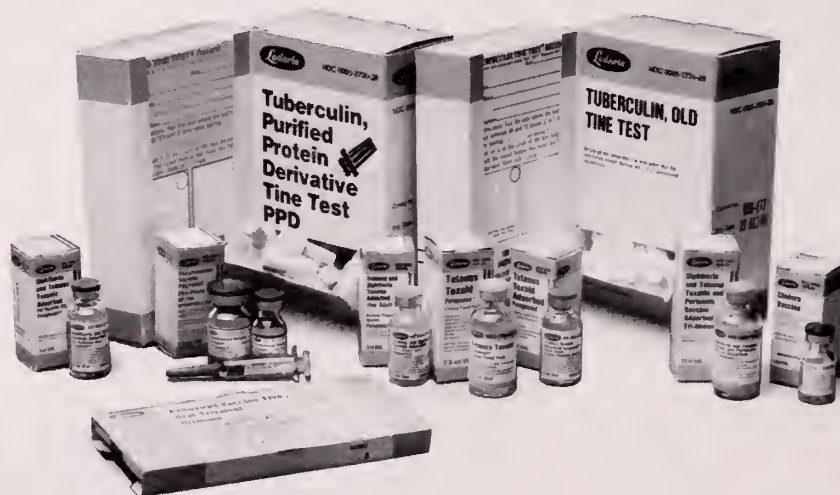


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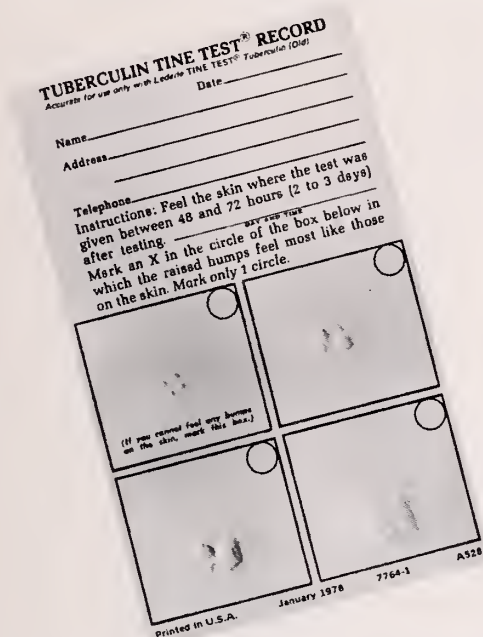


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JUNE

Renal Vascular Hypertension,
June 1, Holy Cross Hospital
Medical Building, Ft. Lauderdale.
For information: Jon Fichtelman,
M.D., Post Office Box 23460,
Ft. Lauderdale 33307.

**The Ninth Annual Florida
Perinatal Conference,** June
4-5, Orlando Marriott Inn, Orlando.
For information: Gregor Alexan-
der, M.D., Newborn Services,
1414 South Kuhl Ave., Orlando
Regional Medical Cntr., Orlando
32806.

**Electrolyte Imbalances Re-
lated to Hypertension,** June 8,
Manatee Memorial Hospital,
Bradenton. For information: Eli
N. Lerner, M.D., 300 Riverside
Dr., East, Suite 2600, Bradenton
32508.

**Nutrition in the Small Prema-
ture Infant,** Lake General Hos-
pital, Lakeland, June 8, 10, 15.
For information: Ronal Haskins,
M.D., P.O. Box 927, Lakeland
33802.

**Conferences in General Medi-
cine and Family Practice,** June
9, International Medical Center,
Miami. For information: Alfredo
Crucet, M.D., P.O. Box 016700,
Miami 33101.

**33rd Annual Scientific Assem-
bly,** June 9-13, Fernandina
Beach. For information: Guy T.
Selander, M.D., 4057 Carmichael
Ave., #229, Jacksonville 32207.

**Clinical Pathology Confer-
ence,** June 11, Brandon Com-
munity Hospital, Brandon. For
information: Dr. Hassen
Hoghooghi, St. Mary's Hospital,
Dept. of Pathology, Brandon.

**1982 Spring Medical/Surgical
Symposium** June 12-13, Palm
Bay Ramada Inn, Palm Bay. For
information: Thomas A. Netter,
M.D., Roseland Plaza, Suite #13,
Sebastian 32958.

**Mental Health Issues in Pri-
mary Care,** June 14-15 and June
24-25, Florida Mental Health
Institute, Tampa. For information:
Rob Ehrlich, M.D., Northside
Community Mental Health Cen-
ter, 13301 N. 30th Street, Tampa
33612.

**Re-Entry; The Anatomy of
Arrhythmias,** June 15, Holy
Cross Hospital, Ft. Lauderdale.
For information: Jon Fichtelman,
M.D., Post Office Box 23460, Ft.
Lauderdale 33307.

Tumor Board Meeting, June
18, Pompano Beach. For infor-
mation: Steven Valenstein, M.D.,
941-0993.

**Common Toxicologic Emer-
gencies and Pediatric Ad-
vanced Life Support,** June 23-
26, South Seas Plantation,
Captive Island. For information:
Dr. James Hillman, Emergency
Care Education Center, P.O.
Box 18091, Tampa 33679.

**18th Annual Resident's Day in
Ophthalmology,** June 18-20,
Bascom Palmer Eye Institute,
Miami. For information: Dr.
Wilson Wallace, Department of
Ophthalmology, University of
Miami School of Medicine, Miami.

**Urological Problems Encoun-
tered in a Clinical Practice,**
Orlando Hyatt House, Kissimmee.
For information: Leroy J. Pickles,
M.D., Emory University School
of Medicine, Woodruff Medical
Center Administration Building,
1440 Clifton Road N.E., Atlanta,
Georgia 30322.

**Conference on Reyes Syn-
drome,** June 25, USF College of
Medicine, Tampa. For infor-
mation: R. Fernandez, M.D., 12901
N. 30th St., Box 15, Tampa 33512.

**ECG Interpretation and Ar-
rhythmia Management,** June
25-27, Orlando Hyatt House,
Orlando. For information: Inter-
national Medical Education Cor-
poration, Division of Postgradu-
ate Education, 64 Inverness Drive
E., Englewood, Colorado 80112.

JULY

**Curso de Medicina Ocupa-
cional (in Spanish)** July 12-16,
Miami. For information: Rafael
Penalver, M.D., Dept. of Office of
International Medical Education,
P.O. Box 016960, Miami 33101.

Ambulatory Electrocardiography: Clinical Applications, Methodology and Interpretation. July 16-18, Orlando Hyatt. For information: International Medical Education Corporation, Division of Postgraduate Education, 64 Inverness Drive E., Englewood, Colorado.

AUGUST

Arrhythmias and Cardiac Ischemia: Diagnosis and Management, Aug. 13-15, Hilton Gateway, Orlando. For information: International Medical Education Corporation, Division of Postgraduate Education, 64 Inverness Drive E., Englewood, Colorado 80112.

Fundamental and Clinical Aspects in Internal Medicine (A Review for the Boards in Internal Medicine) Aug. 1-14, Key Biscayne Hotel, Key Biscayne. For information: Dr. Jose Bocles, Dept. of Medicine, University of Miami, School of Medicine, P.O. Box 016960, Miami 33101.

Comprehensive Review Course for ECFMG, FLEX, VOE (In English) Aug. 16-Nov. 24 (runs the full three months), Four Ambassadeur Towers Condominium, Tower 3, Suite 1950, Miami. For information: Rafael Penalver, M.D., University of Miami School of Medicine Office of International Medical Education, Miami 33101.

Basic Mechanisms and Clinical Applications of Slow-Channel Blockers, Sept. 7, Holy Cross Hospital, Fort Lauderdale. For information: Jon R. Fichtelman, M.D., P.O. Box 23460, Fort Lauderdale 33307.

Common Knee Problems in the Professional Athlete, Sept. 8, Lakeland Yacht and Country Club, Lakeland. For information: Dr. Eugene L. Nagel, M.D., P.O. Box 927, Lakeland.

SEPTEMBER

Tips, Tricks, Traps and Techniques, Recent Developments in Family Practice, Sept. 9-12, St. Augustine. For information: James R. Biggerstaff, M.D., 1406 Kingsley Ave., Orange Park 32073.

Polk County Medical Association 1982 Dinner Meeting Programs, Sept. 8, Lakeland. For information: Eugene L. Nagel, M.D., P.O. Box 927, Lakeland 33802.

Left Ventricular Dysfunction, Ventricular Ectopy and Sudden Cardiac Death, Sept. 21, Holy Cross Hospital, Fort Lauderdale. For information: Jon Fichtelman, M.D., Post Office Box 23460, Fort Lauderdale 33307.

OCTOBER

16th Family Practice Review, Oct. 4-8, Hotel Royal Plaza, Lake Buena Vista. For information: Lamar Crevasse, M.D., Box J-233, JHMHC, Gainesville 32610.

8th Annual OB/GYN Review Course, Oct. 8-16, Royal Biscayne Hotel, Key Biscayne. For information: University of Miami School of Medicine (305) 547-6944.

Violent Crime: An Epidemic, October 13, Quality Inn, Cypress Gardens, Winter Haven. For information: Eugene L. Nagel, M.D., P.O. Box 927, Lakeland.

Brief and Emergency Psychotherapy — A Seminar, Sarasota Hyatt House, Sarasota. For information: Nancy Skotchdopole, ACSW at (904) 496-3515.

89th Annual Meeting of the Association of Military Surgeons of the U.S., Oct. 17-21, Convention Center, Sheraton Twin Towers Hotel, Orlando. For information: Captain Jay R. Shapiro, USPHS (305) 496-3515.

NOVEMBER

Pacemaker Electrocardiography and Dual Chamber Pulse Generators, Nov. 3-5, Wolfson Auditorium, Mount Sinai Medical Center of Greater Miami, Miami Beach. For information: Philips Samet, M.D., (305) 674-2311.

Clinical Management of Coronary Disease and Dual-Mode Exercise Testing, Nov. 5-7, Hilton Gateway, Orlando. For information: Stephen E. Mattingly, International Medical Education Corporation, 64 Inverness Drive E. Englewood, Colorado 80112.

32nd Annual Postgraduate Seminar — Glimpses Forward — Clinical Applications of New Diagnostic Imaging and Interventional Techniques, Nov. 11-13, Mount Sinai Medical Center of Greater Miami. For information: CME Coordinator, Dept. of Continuing Medical Education, 4300 Alton Road, Miami Beach 33140.

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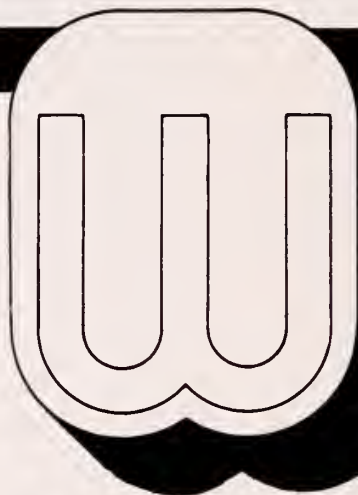
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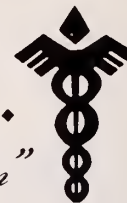
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Robert E. Windom, M.D., Sarasota internist, was installed at Hollywood on May 9, 1982, as the 106th President of the Florida Medical Association.

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Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*), *H. influenzae*, and Group A beta-hemolytic streptococci
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*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

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URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE. Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg t.i.d. body weight > 20 kg (44 lbs) 250 mg t.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day t.i.d.‡
Skin & Skin Structures	250 mg to 500 mg q.i.d.‡	50 to 100 mg/kg/day‡
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.

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1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.

2. Multicenter trials. Data to be published.

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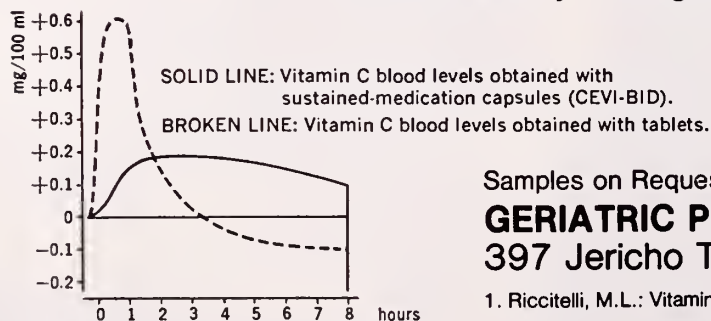
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1. Riccitelli, M.L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20:34, 1972.
2. Riccitelli, M.L.: Vitamin C—A Review. Conn. Med. 39:609, 1975

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The house of medicine

As I begin my term as President of our Florida Medical Association, I sincerely want each of you to know how appreciative I am of having been elected to serve in this high office. Although my one year of leadership is only a small segment in the history of the FMA since its origin 108 years ago, I feel confident that it will enhance the continuation of this strong organization.



Success in any endeavor depends on the commitment of all involved to strive for excellence. Like a chain, weak links in the structure of FMA can equally degrade the quality of performance. My effort will be to constantly work toward preventing the development of any weak links.

I wish I could predict that the next twelve months will be clear sailing. At this moment localized areas of turbulence are evident. The greatest one is professional liability. Repeatedly over the past decade the intensity of this problem has escalated to the present point of virtual eruption. How we meet this storm and our strategy to conquer it will be critical to the economic stability of the practice of medicine.

Another area less turbulent but constantly cloudy is that of the strength of the house of medicine. In its earlier days this house resembled a dominant landmark among professionals.

Weakened segments have gradually appeared over the years, primarily in the roof of this house. Picture this house with the floor made up of county medical societies, the walls standing as the state organization, and the roof our national body, the AMA. Missing shingles to the tune of approximately 50% make the roof vulnerable to stresses that could easily be resisted if its component shingles were virtually 100%. We members who make up the strength of the floor and walls of this worthy structure must direct our attention to our colleagues who now represent those missing roof shingles. Only by unity of purpose of each member can the house of medicine be made to withstand any assault.

Throughout the year we will find stones of various sizes thrown against our "house". How great the damage will be depends on the strength of the area attacked. I feel that the floor and walls are independently indestructible. Yet how good is a house with a leaky roof? My goal will be to end my year in this office showing that our repair efforts to the roof of the Florida House of Medicine will find it equally as strong as its component parts. Your individual and collective participation with me in this endeavor will be essential. I challenge you to start today on this job so we can look to a future that will leave a comfortable, secure home for those who follow.

Robert E. Windsor, M.D.

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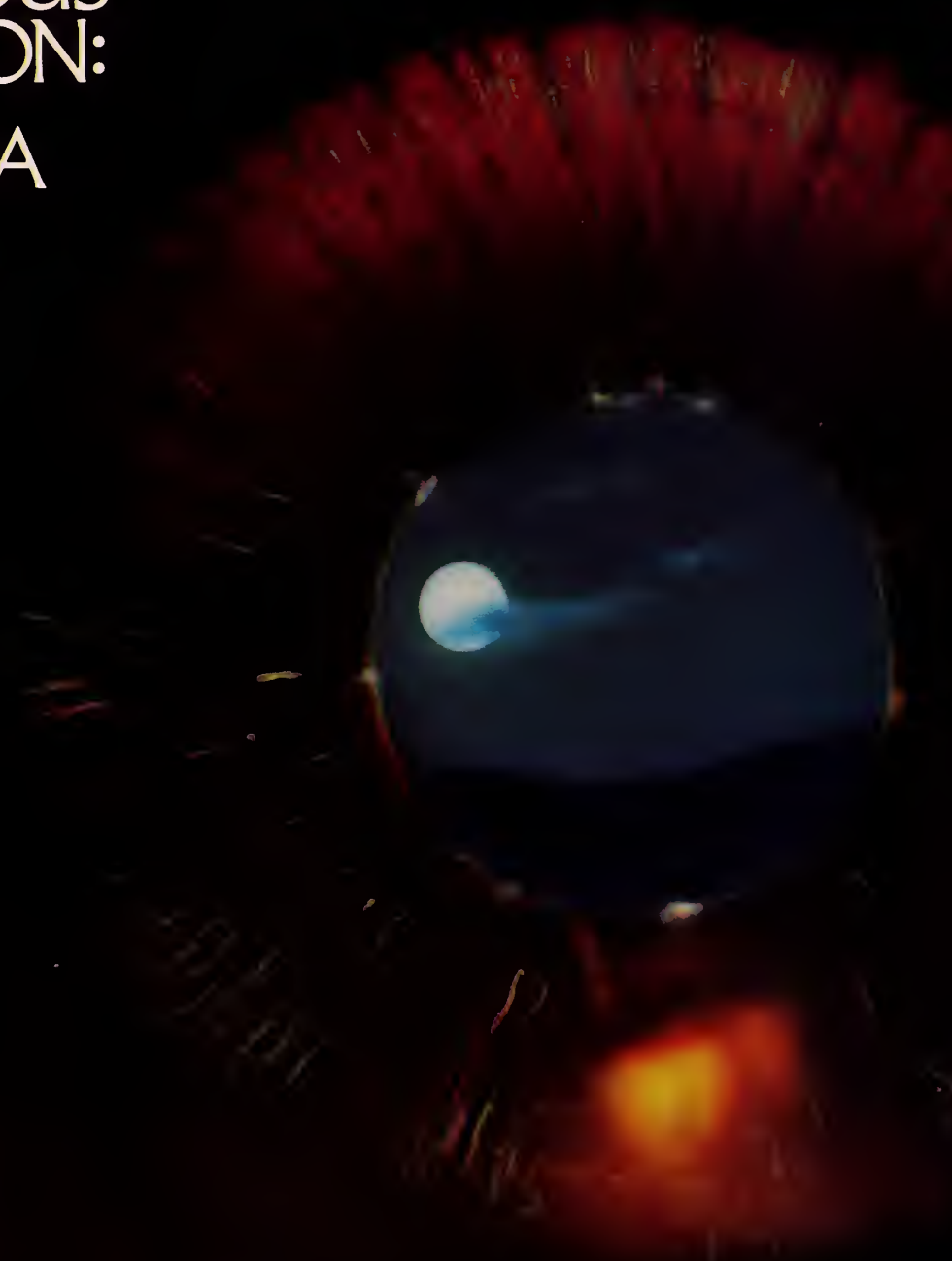
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Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses). Myocardial infarction and stroke reported with use of this class of drugs. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies.

Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt). Bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Packs of 50.

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His interest in dance, theatre and storytelling began during his early school years and continued through college to the present time.

As for most schools for the deaf, Sam Edwards states emphatically, "Hearing Authorities refuse to listen to deaf people's opinions. They are deaf and blind. They want deaf people to talk, to wear hearing aids and to be like hearing people. Many deaf people including myself are left with bad scars because of our experiences at school."

One of the points that Sam Edwards stresses is that there is already too much violence in the world and he doesn't believe in being violent or militant on his behalf or for deaf people as a group.

So Sam Edwards' militancy takes the form of encouraging other deaf people to pursue all art forms as a means to express their creativity and to gain exposure anywhere and everywhere possible. In fact, he wants deaf people to become the visible as opposed to the invisible minority.

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**Robert E. Windom, M.D.
106th President
Florida Medical Association**



Robert Emerson Windom, M.D. New president of FMA

Bob Windom was born in Columbus, Ohio, but moved in 1945 to Sarasota where he finished high school. He attended Duke University for eight years and received his M.D. degree there.

He spent the next four years at Parkland Memorial Hospital for internship and residency training in internal medicine. One of those years was spent in an American Heart Association research fellowship.

Bob moved back to Sarasota in 1960 to practice internal medicine and cardiology. Because of his record of serving in many leadership roles in high school and college (he received the prized key of Omicron Delta Kappa at Duke), it was to be expected that Bob would emerge as a leader in his local medical society and in community activities. True to form, he has held virtually every important position in the Sarasota County Medical Society and his two local hospitals.

Being strongly aware that all citizens of a community must contribute to the continuing quality of that community, Bob became President of the Sarasota County Chamber of Commerce in 1971. He is an enthusiastic supporter of the voluntary health agencies in their role of assisting organized medicine by informing the public and seeking voluntary contributions to conduct medical research. He became President of the Florida Heart Association in 1972.

Bob became active in the Florida Medical Association when he was first appointed Chairman of the Council on Voluntary Health Agencies. This was followed by appointment to the Chair of the Council on Medical Services and then election as Secretary of the Association in 1976. He served in the latter position for five years prior to his selection as President-Elect of the Association in 1981. In each of those six elections he was unopposed.

With this record of distinguished service, Robert Emerson Windom, M.D., ascended to the presidency of the Florida Medical Association at the 108th Annual Meeting in Hollywood on May 9, 1982.

Being fully aware of the involvement of government at all levels, particularly with regard to health care activities, Bob ran unsuccessfully for the Florida Legislature in 1976. In 1978 he was asked to join a group of 200 citizens from throughout the United

States known as the Republican Senatorial Trust, whose purpose is to work for and help elect Republican senators throughout the United States. He serves on the Board of Directors of the Florida Medical Political Action Committee (FLAMPAC) and participates in the national legislative activities of the FMA.

He helped coordinate efforts to establish a Senior Friendship Center Health Clinic in Sarasota which utilizes the services of retired physicians providing medical assistance for underserved senior citizens. His keen interest in the problems of aging resulted in his appointment by HHS Secretary Schweiker to a four-year term on the National Advisory Council on Aging.

As a strong supporter of the free enterprise system, Bob strives to get other physicians involved in local, state and national organized medical affairs, as well as to participate in local civic activities. He feels that physicians are in a unique position not only to direct patients in maintaining good health, but also to help the citizens of the community to maintain a high respect for the American way of life. He feels that physicians should be involved in educating the public about the multitude of health issues. Bob personally does this by hosting a weekly one-half hour television show in Sarasota with many physician guests, as well as producing a 90-second weekday medical tip on the evening news. Through mutual understanding of medical problems he feels that the physician-patient relationship can be maintained and enhanced.

If we were limited to one word to best describe Bob's leadership talents, that word would be *indefatigable* but since we're not limited, let's add *enthusiasm, empathy, experience* and *dedication*.

The problems facing medicine appear to increase constantly. We have been blessed with extremely able presidents in the FMA in recent years. Robert Emerson Windom, M.D., will continue this proud tradition as President of the Florida Medical Association.

Karl R. Rolls, M.D.
Sarasota

Invasive vulvar carcinoma

Elsewhere in this issue of *The Journal* appears an article entitled "Invasive Carcinoma of the Vulva: Some Changing Trends in Surgical Management", of which Denis Cavanagh, M.D., of the University of South Florida College of Medicine is the principal author.

Dr. Cavanagh and his colleagues present an extensive experience with one of the most readily diagnosable genital neoplasms yet paradoxically the one with the greatest patient and physician delay. Indeed the authors stress this point as one-third of their patients had Stage III or IV disease at the time of therapy based on a retrospective International Federation of Obstetricians and Gynecologists staging classification of the primary growth only. Possibly because of this significant percentage of advanced primary lesions, 83 (40%) of 210 patients undergoing node dissections had disease involving the nodes. It has been documented in several previous reports, that given comparable therapeutic regimens, survival is directly related to nodal involvement. Indeed, survival in published series where nodal involvement is absent is in the range of 90-100%.^{1 2 3} Positive nodes on the other hand reduce the five-year survival rate to 30%-50%.^{1 2} This confirms the impression that early diagnosis is tantamount to cure.

Dr. Cavanagh obviously has had extensive experience with the management of vulvar carcinoma and indeed this knowledge and experience must be respected and heeded. Not specifically mentioned in this article — but an area that I feel must be stressed — is that invasive vulvar disease must be treated by individuals with the experience and expertise of the author. The pre-, intra- and post-operative management of this elderly group of individuals should not be casually undertaken on an infrequent basis by inexperienced surgeons. An operative mortality (up to 28 post-operative days) of 6% by an experienced oncologist should underline the magnitude of the problem.

While agreeing generally with the authors in their recommended approaches to diagnosis and therapy, I would raise several areas for further consideration. It is well recognized that vulvar carcinoma occurs in the epithelium of the anogenital tract and that the cervix, vagina, perineum and anus are also at risk.

Obviously diagnostic efforts must be undertaken to rule out multifocal disease in this area. Cytology, inspection, staining and biopsy are the most effective techniques to do this. Colposcopy in this age group in my experience has been unrewarding as only rarely does vulva carcinoma metastasize without regional lymphatic involvement. In view of this knowledge, I do not think that routine IVP and barium enema examinations, in absence of symptoms, are warranted. The greatest yield in early diagnosis will be accom-

plished by suspicion, awareness and simple examination with liberal biopsies.

The authors have reiterated the position that the treatment of choice is radical vulvectomy with bilateral groin dissection. Based on the more recent trends of this series the authors now recommend a pelvic lymphadenectomy only if positive nodes are found in groin dissection. This is also well accepted treatment protocol now. However, the authors recommend that "routine pelvic lymphadenectomy is indicated under the following circumstances:

1. The inguinal lymph nodes are positive, on frozen section
2. The clitoris is involved with the lesion
3. The urethra, vagina, or anus, is involved with the lesion
4. The patient has a melanoma of the vulva
5. A carcinoma of the Bartholins gland is present

As noted previously, positive inguinal nodes are accepted reasons for proceeding with pelvic nodal therapy. However, I do not find supporting data within the series to support the other circumstances dictating pelvic lymphadenectomy. While it is possible anatomically to demonstrate direct lymphatic pathways to the pelvic nodes, this has occurred in only 0-3% of situations without superficial involvement.^{3 5} Indeed, Curry et al⁶ found no positive deep nodes with clitoral involvement in the absence of positive superficial nodes. Melanoma and adenocarcinoma of the Bartholin glands are relatively rare and it is difficult to be dogmatic concerning therapy of these entities. "Routine" pelvic lymphadenectomy is not without morbidity and adds significantly to the operative time. It must be clearly shown to be of value to justify the additional risk.

Despite the recommendation and acceptance of radical vulvectomy and groin dissection as the preferred therapeutic modality, surgical complications and patient acceptance are less than optimum. Hospitalization is prolonged, healing is delayed, scarring is significant, sexual dysfunction is common and lymphedema may be permanent. It is therefore incumbent upon physicians with the volume and experience of the authors to search for improved therapeutic procedures. They cite articles by Daly and Million⁷ and Morley² where a combination of radiation and surgery has been used. Disaia et al⁸ and Parker⁹ have suggested less aggressive surgical approaches for very early invasive lesions. The GOG (Gynecologic Oncology Group Cooperative Study) has a protocol to evaluate the best treatment for suspected pelvic lymph node disease. At present inadequate data is available to embrace these concepts but they do provide avenues for further investigation. Hopefully new and less morbid modalities will be found to treat what appears to be an increasingly diagnosed disease.

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*Robert C. Nuss, M.D.
Jacksonville*

(Editor's Note: Dr. Robert C. Nuss is Director of the Division of Gynecologic Oncology, University Hospital of Jacksonville).

Competition

It appears that the buzz word of the '80's will be "competition". That sounds reasonable enough but after hearing some of the proposals and discussions regarding it, I am filled with the realization that the concept, when applied to the Health Care Industry, (pardon, I detest that term, but it has been forced upon us) evokes different images in different people. For this reason, when we evaluate any competition plan or competitive effort, I believe there are some axioms which should be kept in mind.

1. As presently structured, the medical profession behaves perversely in response to market forces.
2. When a new medical service is supplied, a demand will materialize, even when it was not apparent previously.
3. The demand for medical services is insatiable when the patient is relieved of the responsibility for paying the bill.
4. Increased volume of services and improved efficiency in their performance does not result in a unit cost decrease to the patient.
5. An overabundance of doctors results in fewer services provided by each and higher fees.
6. The patient is unable to evaluate quality of medical care, being attracted by other factors which may or may not be related to such quality.

If these points are accepted as axiomatic — and I recognize that some will not accept them — then it seems clear that competition, as traditionally practiced, can not be an effective cost reduction measure.

Competitive efforts are designed to create a demand for a service or product and yet, the target population, all of society, is unable to evaluate its need and whether or not the price is fair and reasonable. How can a patient possibly shop for medical care? From the time of earliest recorded medical history it has been accepted that only a doctor could evaluate the quality of medical care and thus was responsible for assuring the highest possible quality for his or her patient. From a practical standpoint, the doctor did the shopping for the patient whenever the patient was referred or hospitalized. Thus developed the various Codes of Ethics which set the standards and protected this unique and sensitive relationship.

Hospitals compete for admissions by offering doctors pleasant surroundings, convenience, free meals, recreational facilities, and whatever other perquisites the imagination can dream up. They vie for the patients demand by offering frills, food, personal attention, and a hotel-like atmosphere. This is not to say these things are incompatible with high quality care. It is to say that they are not compatible with the main purpose of competition, to deliver a better product at a lower price; but then, no one until recently, really cared about the price.

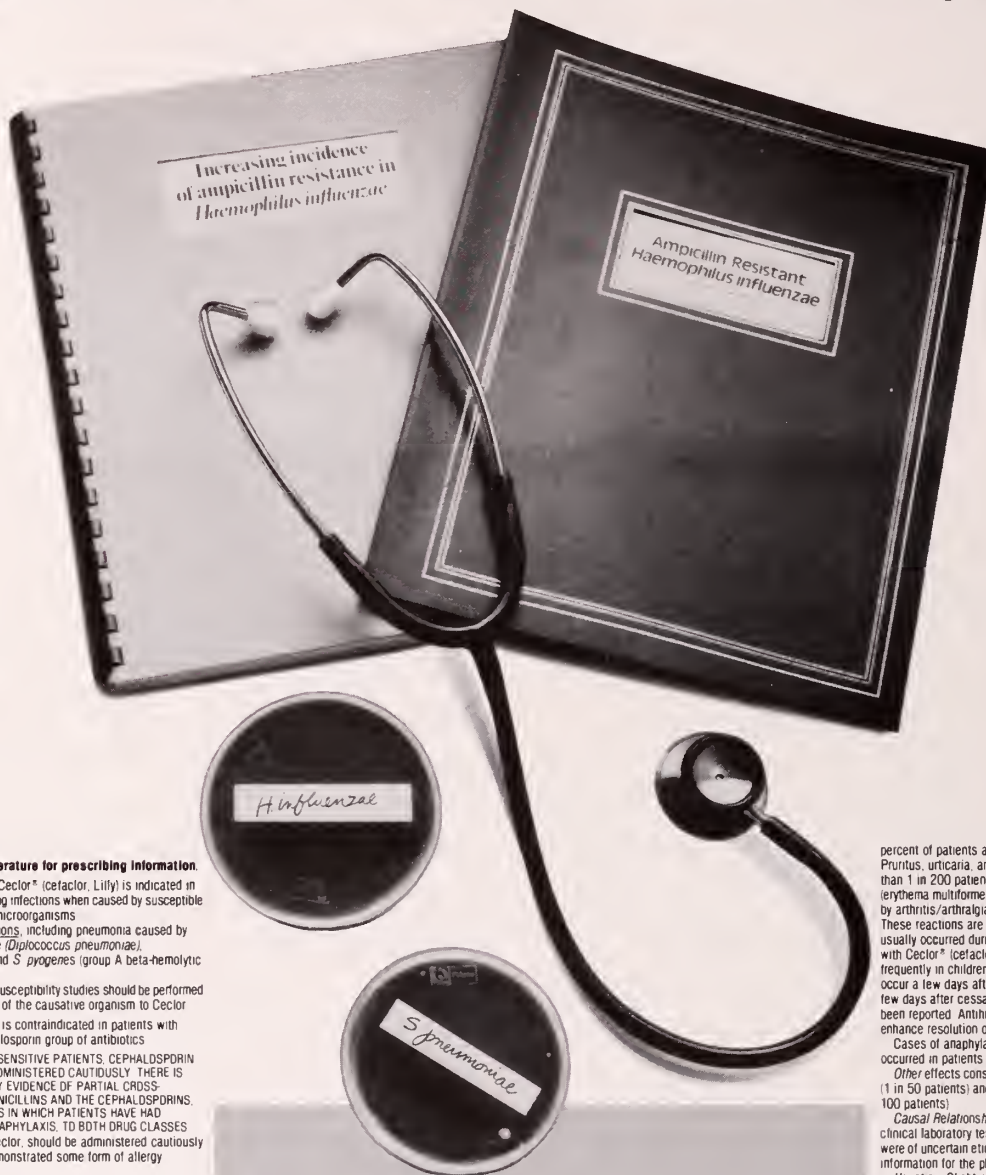
My generation has seen the development of influences which created those axiomatic situations which I allege to exist. Recently a colleague of mine remarked that health insurance has made doctors wealthy but has destroyed the medical profession.

If we are to do more than pay lip service to cost containment, we must demand that our reimbursement system restore to the patient more of a financial stake in his treatment. The physician then, will again be a true patient advocate, balancing quality, necessity, and price, thereby permitting the patient to make his own cost-benefit decisions. The patient will also be in a position to determine whether he received full value for dollar spent. This will require physicians to exercise considerable restraint in setting fees and will certainly bring about an increase in uncollected fees but it makes more sense than to expect individuals to choose among competing insurance programs which all maintain the same reimbursement policies that put us where we are today.

*James K. Conn, M.D.
Assistant Editor
Tallahassee*



An added complication... in the treatment of bacterial bronchitis*



Brief Summary.

Consult the package literature for prescribing information.

Indications and Usage: Cefaclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefaclor.

Contraindication: Cefaclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefaclor, should be administered cautiously to any patient who has demonstrated some form of allergy particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefaclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefaclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antiteratogenic effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in fetuses given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefaclor.

Hypersensitivity reactions have been reported in about 1.5

percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefaclor* (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain: Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). (100281R)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefaclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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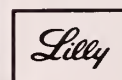
Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefaclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefaclor.⁷

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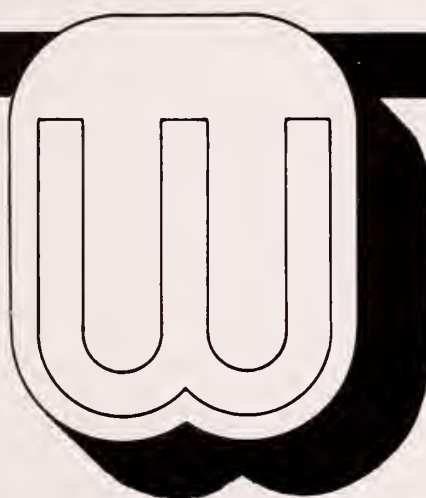
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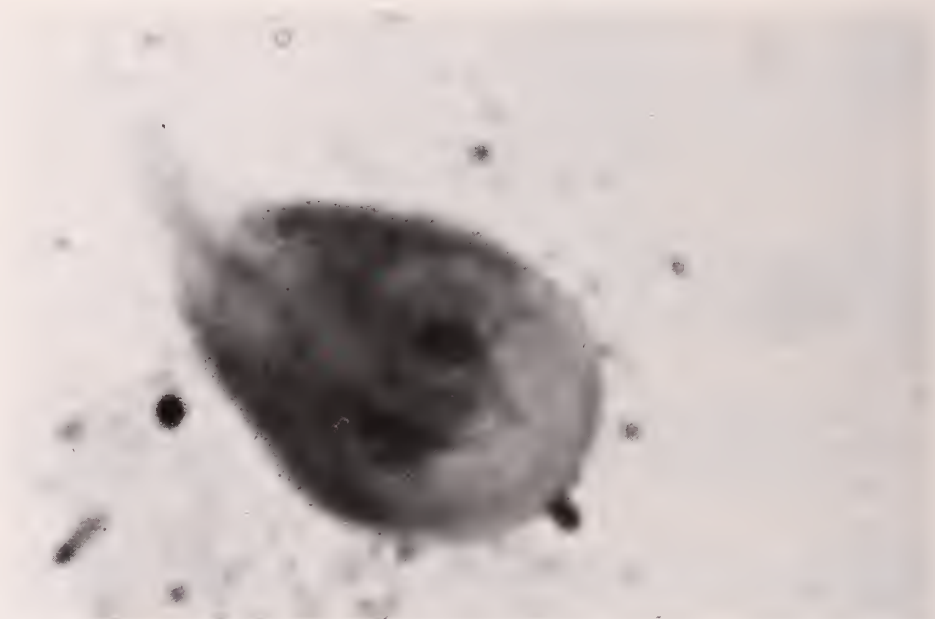
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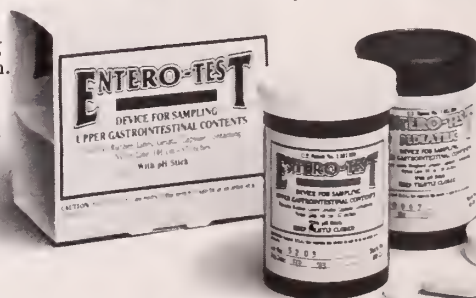
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Invasive carcinoma of the vulva

Some changing trends in surgical management

**Denis Cavanagh, M.D.; John H. Shepherd, M.D.; Hora Praphat, M.D.;
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ABSTRACT: Twenty-five years experience with 286 patients having invasive carcinoma of the vulva is presented. Over 90% had squamous carcinoma. Two hundred thirty six were treated surgically, 120 with radical vulvectomy and bilateral groin and pelvic lymphadenectomy. Although only 76 had radical vulvectomy with bilateral groin dissection, this now appears to be the treatment of choice. There were no intraoperative deaths but 14 (6%) died within 28 days of operation. The absolute five year survival rate was 69% with negative nodes and 33% with positive nodes. The overall absolute five year survival rate was 61%. One third of the cases presented as Stages III and IV and earlier diagnosis and referral must be encouraged in order to improve these results. Among 13 patients with advanced disease treated with radical vulvectomy and exenteration, the five year survival rate was 50%.

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Invasive cancer of the vulva is uncommon. It accounts for 0.3% of all female cancers at a rate of 1.5 per 100,000 females in the United States. There are approximately 500 deaths annually from cancer of the vulva in the United States, and the death rate is approximately 0.5 per 100,000 females or about 0.3% of all female cancer deaths.¹

Just 30 years ago, the five year survival rate for patients with vulvar carcinoma was in the region of 15%.² This appalling state of affairs was largely accounted for by delay in diagnosis, unsound treatment and the then prevalent opinion that these patients were beyond the pale of definitive therapy. The steady increase in life expectancy has brought vulvar cancer into a more prominent place among gynecologic malignancies and during the past three decades there has been a more concentrated attack on the problem.³⁻¹⁵

Improved survival rates have resulted from emphasis on early diagnosis, a better understanding of the nature and modes of spread of the disease, and a more extensive surgical approach. In the past, the generally accepted treatment of invasive carcinoma of the vulva consisted of radical vulvectomy with bilateral groin and pelvic lymphadenectomy. There is evidence that "microinvasive carcinoma" of the vulva may be treated safely without bilateral groin node dissection^{13,16} but other workers strongly disagree.^{12,17} A plea for individualization with regard to therapy has been made,^{18,19} and it is evident that a consensus must be reached on the definition of "microinvasion" before a decision on the standard treatment can be made.

Our interest in invasive carcinoma of the vulva has been stimulated by the referral of 60 patients with this disease to the Division of Gynecologic Oncology

at the University of South Florida within a three year period. This has led us to review our collective experience with this disease over a 25-year period.

Method and Materials • During the period July 1, 1955 through December 31, 1980, 286 patients with cancer of the vulva were treated. Fifty patients were omitted for a variety of reasons such as "microinvasive carcinoma," treatment with radiotherapy and inadequate data. The remaining 236 patients with invasive carcinoma were treated surgically. The data on these were analyzed and provide the basis for our current views on management. The patients' ages ranged from 24 to 92 years with a median age of 67 years. On reviewing the epidemiologic profile, race, parity and weight appeared to play a significant part. Our high risk patient was typically caucasian, nulliparous, and weighed over 150 pounds. Other coexistent problems of note were diabetes (12%), syphilis (6%), invasive cervical carcinoma (4%), other cancers (3%), and venereal granulomatous disease (3%). Two of our patients were pregnant at the time the diagnosis of carcinoma of the vulva was made.

Delay in diagnosis appeared to be a significant problem. Among patients delay of over 12 months was apparent in 89 (38%) and five did not consult the first physician until the lesion had been present on the vulva for over ten years. This finding underscores the need for patient education in this area. There was also significant physician delay, with prescription of local ointments for significant lesions instead of performance of a biopsy being the cardinal error. There is no question that more patients should have had a biopsy taken sooner than it was. All that is required to perform a biopsy is 1% lidocaine, a 25 gauge needle, a 4 mm cutaneous biopsy punch (Keyes), and a pair of scissors. The tissue is removed with a circular motion and rarely is a suture necessary to control bleeding. The use of the toluidine blue test to select sites for biopsy is also worthwhile.²⁰ Early diagnosis is essential if optimal results with this disease are to be achieved.

The clinical stage of disease had to be worked out retrospectively because most of the patients antedated the introduction of the FIGO classification. Using only the primary tumor site, clinical stages were computed I to IV. This provides a rough guide to the stage of the disease at the time of diagnosis. Ninety-four patients (40%) were in Stage I, 61 (26%) in Stage II, 54 (23%) in Stage III and 27 (11%) in Stage IV (Table 1). Thus, one third of our patients had Stage III or Stage IV disease at the time of initial diagnosis. This again emphasizes the need for improved patient and physician education.

The pathology of the lesions found in 236 patients is given in Table 2. The taking of a careful history and performance of a thorough physical examination are obviously important because all treatment

should be tailored to the needs of the individual patient. Although we believe that the staging of carcinoma of the vulva should be carried out at the time of operation (as in staging of carcinoma of the ovary), the careful preoperative palpation of groin nodes provides useful information for planning the surgical procedure. It has been our experience that when a patient has significantly enlarged nodes in the groin, there is a 50% chance that this is due to metastasis, whereas when the nodes are not significantly enlarged less than 10% show evidence of groin node metastasis.

Pretreatment Investigation • When a patient with vulvar carcinoma is seen, a thorough investigation should be undertaken. On the basis of our experience to date we recommend the following:

1. Routine studies to include a complete blood count, urinalysis, SMA (complete), 2-hour postprandial blood sugar, serology, blood typing and cross matching prior to surgery.
2. Papanicolaou smear of cervix, colposcopy of cervix and vulva, toluidine blue test, biopsy of vulvar lesions or toluidine blue positive areas.
3. Screen for granulomatous disease of the vulva if indicated.
4. X-ray of chest, IVP and barium enema.
5. Examination under anesthesia, cystoscopy and sigmoidoscopy or colonoscopy as indicated.
6. Liver scan, bone scan, lymphography, sonography and computerized axial tomography in selected cases.

Table 1. — Carcinoma of the Vulva: Clinical Stage (FIGO).

Stage	Patients
I	94 (40%)
II	61 (26%)
III	54 (23%)
IV	27 (11%)
	236

Table 2. — Carcinoma of the Vulva: Histopathology.

Pathology	Patients
Squamous Carcinoma	216 (91%)
Melanoma	11 (5%)
Adenocarcinoma	9 (4%)
Total	236

Surgical Management • Provided the disease is resectable, we feel that the best treatment for invasive carcinoma of the vulva should be nothing less than extensive excision of the vulva with bilateral groin lymphadenectomy. The primary lesion and groin nodes should be removed in continuity. The operation may be carried out under local anesthesia or epidural anesthesia if the patient is not fit for general anesthesia.

A detailed description of the technique of the basic operation of radical vulvectomy with bilateral regional lymphadenectomy is not necessary here, but we feel that the most important steps are as follows:

1. A "butterfly" incision should be made so as to remove the skin over the inguinal lymph nodes.¹⁴ The tips of "wings" of the "butterfly" will rest on the anterior superior iliac spines, with the upper part of the incision being interspinous in location and the lower part extending along the inguinal skin creases and into the labiocrural folds so as to clear all lesions by 1 to 2 cm (Fig. 1).



Fig. 1. — Radical vulvectomy specimen obtained with butterfly incision.

2. The lymph nodes should be removed in continuity with the vulvar specimen with continuity of the labiocrural lymphatics being maintained with the specimen.
3. The mons pubis should be removed, with special attention being paid to this if the clitoris is involved.
4. The dissection should be carried down to the fascia so that all tissues are removed superficial to the urogenital diaphragm.
5. Resection of the vagina, urethra, anus, or even bone is required if the tumor has involved these sites.
6. Bilateral transplantation of the sartorius muscles should be carried out to protect the femoral vessels. Fixation to the inguinal ligaments is obtained with #00 polyglycolic sutures (Dexon).

Table 3. — Carcinoma of the Vulva: Surgical Procedure.

A. Curative	Patients
Radical Vulvectomy and Groin and Pelvic Lymphadenectomy	120
Radical Vulvectomy and Groin Lymphadenectomy	76
Total Vulvectomy	16
Radical Vulvectomy and Groin and Pelvic Lymphadenectomy and Exenteration	<u>13</u>
	225
B. Palliative	
Radical Vulvectomy and Groin Lymphadenectomy	1
Partial Vulvectomy	<u>10</u>
	11

Using two teams, and starting with bilateral groin dissection, the operation can be completed in two to four hours depending upon the experience of the team and the lesion being dealt with. The treatment of our patients is individualized depending on their general condition and the extent of the disease. All of them now receive "mini-dose" heparin, 3000 units subcutaneously every eight hours until they are ambulating satisfactorily. They also receive cefoxitin prophylactic antibiotic cover, 2 gm IV 16 hours before operation and then every eight hours for a total of 72 hours. The type of treatment received by patients has been categorized into two groups: (a) curative and (b) palliative. Details are given in Table 3.

When the patients receiving potentially curative treatment are considered, certain trends have become apparent as our experience with the disease has increased. Although radical vulvectomy with bilateral groin and pelvic lymphadenectomy was performed in 120 of 225 patients, there is now a trend away from this operation. Radical vulvectomy with bilateral groin lymphadenectomy was performed in 76 patients, and there is an increasing tendency to use this operation with liberal frozen sections being obtained of the groin lymph nodes. If a positive lymph node is found in the groin, then bilateral extraperitoneal pelvic lymphadenectomy is performed unless a contraindication is apparent. With adequate sampling of groin nodes, we feel that the chance of having a positive pelvic node in the presence of negative groin nodes is remote, and we have not found a single case among 120 patients. Total vulvectomy was performed in 16 patients because it was believed that they were unfit for a more extensive procedure and the groin nodes were not palpable. Radical vulvectomy with bilateral groin and pelvic lymphadenectomy and exenteration

(anterior, posterior, or total) was carried out in 13 patients because it was believed that the disease was too extensive to be treated by radical vulvectomy with regional lymphadenectomy. Unlike the situation with cervical carcinoma, it is usually possible to preserve either the bladder or the rectum and total exenteration was only necessary in one of our 13 patients. Positive nodes were found in 83 of 210 patients (40%) in whom node dissections were performed. Sixteen of 133 patients (12%) who had groin and pelvic lymphadenectomies had positive pelvic nodes.

Palliative treatment in the form of radical vulvectomy and bilateral groin dissection was carried out in one patient who was having recurrent hemorrhage from fungating nodes in the right groin. The patient's quality of life was much improved but she died 18 months later of pulmonary metastases. Partial vulvectomy was carried out in 12 patients because they were believed to be unfit for radical surgery.

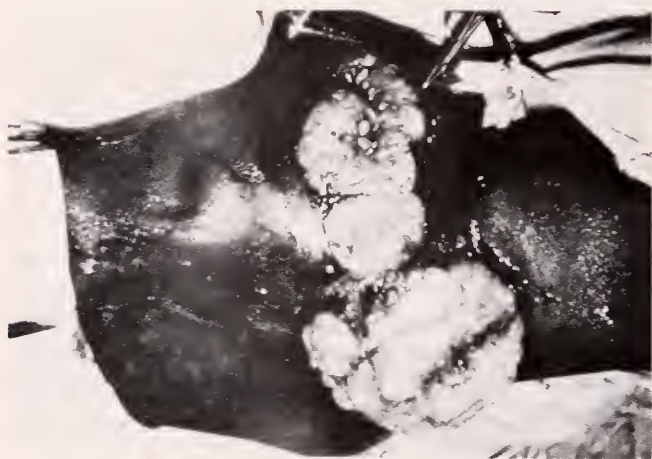


Fig. 2. — Patient with nonresectable but localized disease in whom a radical vulvectomy with bilateral groin lymphadenectomy was necessary for palliative purposes.

Postoperative Mortality and Morbidity •

There were no intraoperative deaths but 14 of 236 patients (6%) treated surgically died within 28 days of operation. (These are summarized in Table 4). Ten of these were due to pulmonary embolism, two to myocardial infarction, and one to postoperative osteomyelitis of the pubis with fulminating septicemia. The patient had been treated 15 months previously with radiotherapy. One patient died from hemorrhage within 24 hours of a further plastic surgical procedure.

The main cause of morbidity in the 210 patients who received a radical vulvectomy and groin dissection was groin wound breakdown. This occurred to some degree in 179 of 210 patients (85%). We believe this can be markedly reduced with the "butterfly" incision and my undermining the abdominal wall and bringing it down toward the groins and symphysis pubis. Using this modified technique, our wound breakdown rate has fallen to approximately 20%. If the wound does break down, however, it is treated

with hydrogen peroxide and honey dressings three times daily.²¹ This leads to a clean granulating wound within a short time, and only two patients have required skin grafting in the past 13 years. One of these died within 24 hours of the plastic surgical procedure. Femoral vessel rupture occurred on four occasions early in the series, but the routine use of bilateral sartorius muscle transplantation has eliminated this complication. Persistent lymphedema is a serious problem. This occurred in 22 of 210 patients (10%). If cellulitis is present, it should be treated with penicillin. Otherwise, elevation of the legs appears to be the most effective method of dealing with this troublesome complication. The operative treatment of lymphedema is unsatisfactory at this time. Within two years, collateral lymphatic pathways become established, and the situation improves provided the legs have not been allowed to become chronically edematous.

Results and Discussion • The absolute five year survival rate by clinical stage was 76% for Stage I, 58% for Stage II, 28% for Stage III, and 50% for Stage IV (Table 5). If estimated by the life-table method, the five year survival rate was approximately 85% for Stage I, and approximately 70% for Stage II. It is of considerable interest that although only ten of 28 patients (36%) with Stage III or Stage IV disease survived for five years, five of ten patients with Stage IV disease treated with exenterative procedures survived five years. Thus, it is felt that there is a definite place for this procedure in selected cases.

With positive lymph nodes the absolute five year survival rate was 33% and with negative nodes it was 69%. The overall absolute five year survival rate was 61%. As pointed out by Shingleton and associates,²² when assessing five year survival rates, it is important to differentiate between absolute survival rates and reports based on the modified life-table method. The absolute five year survival rate for all cases treated by radical vulvectomy with lymphadenectomy ranges from 50% to 70%. In the series from M. D. Anderson Hospital reported by Rutledge, Smith and Franklin,⁷ the five year survival rate for 139 patients treated for cure was 83% using the modified life-table method. Because the patients often have intercurrent disease, this plays a large role in the survival rate. In Rutledge's series 53 patients with negative inguinal nodes were followed for five years or more and none had a recurrence. Thirty-three patients had positive nodes and 13 or 30% survived for five years free of disease.

Most authors agree that radical vulvectomy should be accompanied by bilateral groin lymphadenectomy but Morris¹³ disagrees. This rationale for his therapeutic approach is based on his observation that the contralateral inguinal lymph nodes are rarely positive when the ipsilateral inguinal nodes

Table 4. — Carcinoma of the Vulva: Postoperative Mortality and Morbidity

A. Mortality

Pulmonary Embolism	10
Myocardial Infarction	2
Hemorrhage	1
Sepsis	<u>1</u>
Total	14 of 236 (6%)

B. Morbidity

Groin and Wound Breakdown	179 of 210 (85%)
Femoral Vessel Rupture (arterial 3, venous 1)	4 of 210 (2%)
Chronic Lymphedema	22 of 210 (10%)

Table 5. — Carcinoma of the Vulva, 1955-1975, Absolute Five Year Survival by Clinical Stage.

Stage	Patients	Survival
I	50	38 (76%)
II	36	21 (58%)
III	18	5 (28%)
IV	<u>10</u>	<u>5 (50%)</u>
Total	114	69 (61%)

Note: With Positive Nodes:	33%
With Negative Nodes:	69%
Overall Absolute Five Year Survival:	61%

are negative. Morris advocates analysis of the ipsilateral inguinal nodes and avoidance of a contralateral inguinal lymphadenectomy when these nodes are negative for tumor. This view is not generally held, but in 1981 it had additional support from Iversen and co-workers²³ in Norway. Certainly the conservative approach is worth keeping in mind in management of poor risk patients. With regard to routine pelvic lymphadenectomy, it would appear that there is little value in continuing to do this. In our series of 120 patients with pelvic and groin lymph node dissections done, there was not a single patient with positive nodes in the pelvis without positive nodes in the groins. Thus, we believe that the standard operation for invasive squamous-cell carcinoma of the vulva is radical vulvectomy with bilateral groin lymphadenectomy, but with the liberal use of frozen sections so that if any of the groin nodes are positive a pelvic lymphadenectomy may be performed. Although we feel that routine pelvic lymphadenectomy is not generally indicated, we believe that it is indicated under the following circumstances:

1. The inguinal lymph nodes are positive, on frozen section.
2. The clitoris is involved with the lesion.
3. The urethra, vagina or anus is involved with the lesion.
4. The patient has a melanoma of the vulva.
5. A carcinoma of Bartholin's gland is present.

It should be noted that we had 11 patients with melanoma of the vulva and exploratory laparotomy was performed to exclude metastatic spread prior to performance of radical vulvectomy. Pelvic lymphadenectomy was then carried out in addition to bilateral groin lymphadenectomy and radical vulvectomy. Of the nine patients eligible for five year survival, only three survived. Thus, although we agree with Symmonds and associates²⁴ that melanoma of the vulva should be treated as a squamous carcinoma, we should not expect the results to be as good. As pointed out by Morrow and associates,²⁵ although the results for Stage I and II melanoma of the vulva is approximately 75% for five year survival, for Stages III and IV it is approximately 15%. When the lymph nodes are negative for metastatic melanoma, it is approximately 56% but when the nodes are positive, it is approximately 14%.

Comment • The steady increase in life expectancy in recent years has brought vulvar carcinoma into a more prominent place among gynecologic malignancies. Improved survival rates have resulted from emphasis on early diagnosis, better understanding of the nature and modes of spread of the disease, and a more judicious surgical approach to treatment. On the basis of experience with 236 cases of invasive carcinoma of the vulva, radical vulvectomy with bilateral groin dissection and liberal use of frozen sections is the keystone of management. Pelvic lymphadenectomy appears to be indicated only in selected cases. It is concluded that radical surgery can now be carried out with relative safety in older women and that the results are good with early invasive disease. One third of the patients in this series had late disease, so the greatest hope for improvement lies in earlier diagnosis. However, there also appears to be a definite place for pelvic exenteration for the cure of patients with advanced but localized disease. The management of this disease is often difficult, but the improving five year survival rates and improved quality of life brought to these patients make the effort worthwhile.

Daly and Million²⁶ have suggested that patients with squamous-cell carcinomas of the vulva and negative nodes be treated with radical excision of the vulva followed by elective radiation therapy to the groins and pelvic nodes up to and including the hypogastric nodes. They employ a cobalt 60 source, 80 cm source-skin distance (SSD) and split field treatment. They report minimal subcutaneous induration,

minimal diarrhea, and no evidence of lymphedema of the lower extremities. These authors suggest that this concept is practical and believe that it is probably an improvement on vulvectomy with bilateral node dissection.

Morley¹² has suggested that patients with positive superficial nodes might be treated with pelvic irradiation, giving a dosage of 5000 to 7000 rads to the whole pelvis, rather than have a pelvic lymphadenectomy. This seems to be a reasonable approach and we are using this in some of our more debilitated patients.

In summary, although we firmly believe that the primary treatment for carcinoma of the vulva should be surgical and that there is little place for irradiation, it is evident that in management we must have a broad general plan with room enough for variation to suit an individual patient.

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Effect of propranolol on mortality and morbidity after acute myocardial infarction

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ABSTRACT: Survival following myocardial infarction depends upon preservation of myocardial tissue and control of arrhythmias. Beta-adrenergic blockade has been proposed in the management of these patients. We examined our data retrospectively regarding mortality and morbidity in 101 patients with myocardial infarction. Mean follow up was two years. Patients treated with or without propranolol were comparable in age, hospital course, and type of myocardial infarction. Although the total mortality was not significantly different in the two groups, 12% in propranolol treated vs 24% in untreated (P -NS), a significant decrease in mortality in patients with anterior myocardial infarction was observed (9% vs 37% P 0.03). Morbidity in terms of angina frequency and recurrent myocardial infarction was similar in the two groups. Patients treated with propranolol had no evidence of increase in heart failure symptoms. However, overall functional status in both groups of patients remained similar.

Propranolol has now been in use for the treatment of angina pectoris for a number of years. It has also been shown to be effective in averting myocardial infarction.¹⁻⁵ However indications for its use in the postmyocardial infarction period are not well defined. Some animal and human studies have indicated that propranolol may have beneficial effects on the infarct size.⁶⁻⁸ Follow up studies in patients who had sustained acute myocardial infarction and received β -adrenergic blocking agents have yielded results suggesting a salutary effect in terms of mortality.⁹⁻¹² Double-blind prospective trials in Europe employing long-term therapy with β -blocking agents have revealed significant decrease in mortality in patients on β -blocking agent in comparison to placebo.¹⁰⁻¹² A study using practolol showed a clear improvement in survival of patients only with anterior myocardial infarction.¹⁰ However, a more recent study using timolol has shown both a reduction in overall mortality as well as a decrease in the reinfarction rate in both anterior and inferior wall myocardial infarctions.¹¹ Other studies have not substantiated these results leading to a great deal of controversy.¹³⁻¹⁶ Because of tremendous interest in this area we examined our data with regard to the influence of prolonged therapy with propranolol on mortality and morbidity in patients who had suffered acute myocardial infarction.

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Materials and Methods • One hundred one male patients admitted to the Veterans Administration Medical Center in Gainesville, Florida were included in this study. The average age was 58 ± 4 years (range 34-90 years). All patients had sustained

acute myocardial infarction. The diagnosis was substantiated by at least two of the three following criteria: (a) electrocardiographic changed defined as "very probable" by the WHO electrocardiographic criteria, (b) a very typical history, (c) serum enzyme levels (GOT, CK, LDH) at least twice the upper limits of normal for the hospital laboratory.¹⁷ The locations of myocardial infarction were grouped into three main categories: anterior, inferoposterior, and subendocardial. A history of risk factors such as hypertension, diabetes mellitus, gout, hyperlipidemia and smoking was obtained. The hospital course was monitored as to hypotension (systolic pressure < 100 mm Hg), S₃ gallop, development of mitral regurgitation and arrhythmias.

Of the 101 patients, 50 were given propranolol, whereas the other 51 were not. This was done at the discretion of the treating physician and not in a random fashion. Propranolol was started at two to four days but less than five days following documentation of acute myocardial infarction. Patients who discontinued propranolol or who were started on propranolol during a follow-up period were excluded from this study.

At 10 to 44 months (mean follow up 25 months) the patients were questioned regarding their status. If the patient had expired, close family members were questioned about the clinical status immediately before his death. A questionnaire pertaining to symptoms and cardiac history was mailed to each patient during the specified period of time and data were obtained on the medications and symptoms of chest pain, shortness of breath, fatigue, ankle swelling and palpitations. The patient's condition was classified using the New York Heart Association criteria for evaluating functional status.¹⁸

For statistical analysis the Fishers Exact Test was used.

Results • Both propranolol-treated and nontreated groups were evaluated over a comparable period of time following myocardial infarction. The untreated group was followed for 26 ± 1 month and the treated group for 23 ± 1 month. The age distribution of the two groups was also comparable with a mean age of 59 ± 1 year in the untreated and 56 ± 1 year in propranolol-treated group. The dose of propranolol was 199 ± 27 mg per day in the anterior myocardial infarction group, 214 ± 27 mg per day in the inferior myocardial infarction group and 297 ± 62 mg per day in the subendocardial infarction group. All of these are in similar range. The prevalence of risk factors was similar in the treated and untreated groups of patients. The data regarding the type of myocardial infarction, peak CK values, and hospital course of the patients in each group are presented in Table 1. All these variables were statistically not different in the two groups.

Table 1. — Patient Population Characteristics.

	Untreated Group	Propranolol-Treated Group
	(n = 51)	(n = 50)
Coronary Risk Factors		
Hypertension	28	30
Diabetes Mellitus	12	19
Gout	1	4
Increased Lipids	6	6
Smoking	43	37
Type of Myocardial Infarction		
Anterior	19	23
Inferior Posterior	22	20
Subendocardial	13	7
Mean Peak CK (IU)		
Anterior	321 ± 41	432 ± 35
Inferior Posterior	616 ± 139	677 ± 97
Subendocardial	364 ± 58	496 ± 132
	318 ± 40	228 ± 36
Hospital Course		
Hypotension	0	0
Hypertension	16	9
S ₃ Gallop	7	9
Mitral Regurgitation	12	9
Recurrent Pain	0	0
Atrial Fibrillation	3	3
Supraventricular Tachycardia	2	1
Left Bundle Branch Block	1	2
Ventricular Ectopic Beats	17	1

Follow up data were analyzed with regard to frequency of chest pain, symptoms of heart failure, recurrent myocardial infarction, functional status and death (Table 2).

The survival data showed six deaths in the propranolol-treated group (12%) compared to 12 deaths in the untreated group (24%) (Fig. 1). This difference was not statistically significant. The time of death was similar in both groups, 11 ± 3 months from myocardial infarction in the untreated group and 12 ± 4 months in the treated group (P-NS). Of particular interest was the difference in mortality in patients with anterior myocardial infarction where the incidence of death was significantly less in the propranolol-treated group.

olol-treated patients. Two of 23 patients with anterior myocardial infarction (9%) had died while on propranolol, whereas seven out of 19 patients (37%) with anterior myocardial infarctions not taking propranolol had died. This reduction in mortality was significant ($P < 0.03$) (Fig. 2.). Patients with inferior and subendocardial infarction did not show much change in mortality while on propranolol therapy. Of patients with inferior myocardial infarction only two of 20 (10%) taking propranolol and three of 22 patients (13%) not taking propranolol had expired. Of patients with subendocardial infarction two of seven (29%) had expired while on propranolol, whereas two out of 13 (15%) not taking propranolol had expired. These results in patients with inferior and subendocardial infarction were not significantly different.

The incidence of recurring myocardial infarctions was also similar in the two groups. Ten of 50 patients who were taking propranolol suffered another myocardial infarction compared to 12 of 51 patients not receiving propranolol who had reinfarction. There were no significant differences in frequency of chest pain, consumption of nitroglycerin, or symptoms of congestive heart failure. A very small percentage of patients in both groups returned to any kind of work. Over all, functional status of patients was similar, whether or not they had taken propranolol.

Table 2. — Follow Up Course.

	Untreated Group	Propranolol-Treated Group
	n (%)	n (%)
Chest Pain	40/51 (80)	38/50 (78)
Number of NTG Tablets Consumed per Week	4 ± 1	4 ± 1
Dyspnea	45/51 (88)	42/49 (86)
Orthopnea	6/51 (12)	8/49 (16)
Fatigue	48/51 (94)	47/49 (96)
Edema	20/51 (39)	12/48 (25)
Palpitation	24/51 (47)	23/48 (48)
Recurrent Myocardial Infarction	12/51 (24)	10/50 (20)
Coronary Artery Bypass Surgery	4 (8)	3 (6)
Return to Work	8 (16)	4 (8)
NYHA Class	3.0 ± 0.3	3.0 ± 0.1
NTG — nitroglycerin		
NYHA — New York Heart Association		
n — refers to number of patients		

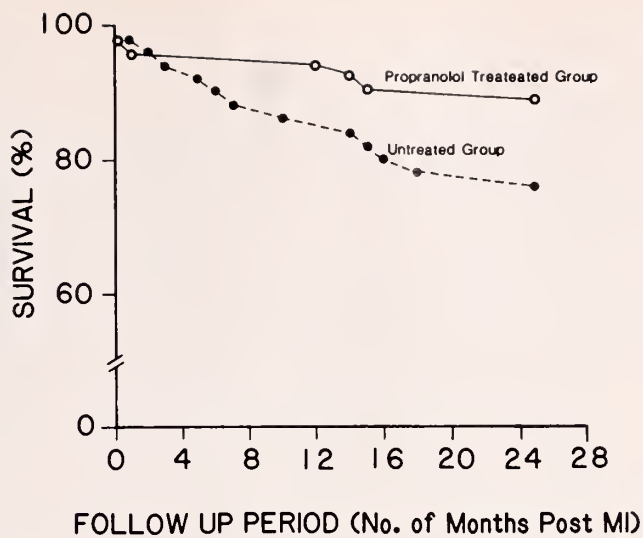


Fig. 1. — Survival in both the propranolol-treated and untreated groups of patients (includes all types of myocardial infarction).

Conclusions • During the peri-infarction period a major objective is the preservation of ischemic myocardium. The hyperadrenergic state during the acute episode has adverse effects by enhancing myocardial necrosis. Thus from this standpoint therapy with β -adrenergic blocking agents may be useful. Some of the known properties of propranolol make it a suitable choice for myocardial preservation. These include a decrease in myocardial oxygen consumption,¹⁹⁻²⁰ platelet aggregation,²¹ plasma free fatty acid levels,²² and a shift in the oxygen-hemoglobin disassociation curve to the right.²³ In some studies, redistribution of blood flow from normal to ischemic myocardium by propranolol has been demonstrated.²⁴ These actions of propranolol may play an important role in the preservation of ischemic myocardium. A decrease in ventricular irritability may be additional mechanism of beneficial actions of propranolol in patients with myocardial infarction.

These properties of propranolol are probably instrumental in the beneficial effects that have been observed on the long-term survival of patients following myocardial infarction. In the practolol study there was no significant improvement in the survival of patients with inferior and subendocardial infarctions who had been placed on long-term β -blockade. Similar results are shown in our patients. It is possible that the small number of patients in this study precludes a definitive answer. However, in patients with anterior myocardial infarction a marked benefit with prolonged β -blockade with propranolol are consistent with previous observations.¹⁰ This selective improvement in patients with anterior myocardial infarction may be due to the fact that the overall mortality is higher in this group of patients because of the

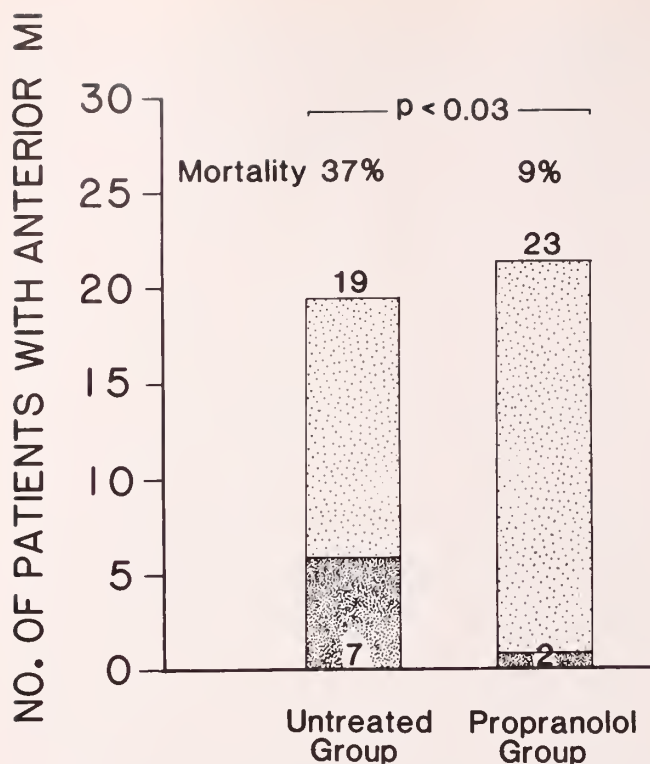


Fig. 2. — Patients with anterior myocardial infarction have lower mortality while treated with propranolol.

large areas of infarct. This efficacy of *B*-blockade with propranolol may be apparent even with a small sample size as in this group.

The factors affecting long-term survival following myocardial infarction have been evaluated, and these include frequency of premature ventricular beats and the extent of myocardial infarction.²⁵ Patients with anterior wall myocardial infarction who frequently have large infarcts may benefit more from the antiarrhythmic effects of propranolol. Propranolol may alter the critical balance of the tissue oxygen demands and supply in the potentially ischemic areas to show a significant difference in long-term survival in this high risk group.

Although the present study has its limitations, namely that it was a retrospective analysis done on a small number of patients and that the selection of patients treated with propranolol was not random, the two groups were similar for comparison. Their age distribution, type of myocardial infarction, symptomatology, risk factors and hospital course were not significantly different.

The results of this retrospective follow up are interesting from a view point of effects of propranolol therapy on cardiovascular morbidity. As shown in Table 2, propranolol therapy did not significantly affect frequency and severity of angina pectoris, nitroglycerin consumption or recurrent myocardial infarction. Incidence of palpitation as reported by the patients was not altered by propranolol. Although propranolol has potent negative inotropic effects, no

increase in symptoms of congestive heart failure was reported by patients taking propranolol. This may be related in part to preservation of ischemic myocardium and adequate maintenance of cardiac performance. A very small number of patients, whether or not they were taking propranolol, returned to work after myocardial infarction. This is not unusual in this group of patients. Propranolol therapy did not influence significantly the number of patients with angina severe enough to require coronary artery bypass surgery. Overall, The cardiac function was similar in the survivors of acute myocardial infarction, whether or not they were prescribed therapy with *B*-blocking agent.

In summary, the results of this study demonstrate that propranolol may be effective in reducing mortality following acute myocardial infarction. Improvement in survival is more marked in patients with anterior wall myocardial infarction. However, the cardiac morbidity is not altered by propranolol in survivors of myocardial infarction. The data from other large prospective trials employing propranolol and other *B*-blockers may provide more definitive answers.

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Sunburn and sunscreens:

An update

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ABSTRACT: *Within the past five years an immense amount of data concerning the biochemistry and pathophysiology of the sunburn reaction has surfaced. With many of the recent developments in chemistry and pharmacology, many new sunscreen preparations, which are cosmetically elegant, while at the same time efficacious in the prevention or reduction of ultraviolet light (UVL) induced erythems, have become available to the general public.*

We present a review and an update of some of the more current developments in the mechanism and prevention of the sunburn.

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Dermatologists have been aware of the relationship between sunlight and skin damage since the first report by Unna in 1894.¹ Twelve years later, Hyde² proposed that cutaneous cancer was the direct result of prolonged ultraviolet light (UVL) exposure. In 1969, Kligman's histologic studies showed the early destructive effects of UVL which began manifestation in children.³ Therefore photoprotection at an early age would appear beneficial in order to diminish some of the acute and chronic effects of exposure.⁴

The UVL spectrum is divided into three bands: ultraviolet-A (UVA) (320-400 nm), ultraviolet-B (UVB) (290-320 nm), and ultraviolet-C (UVC) (220-280 nm). The ozone layer in the stratosphere absorbs virtually all UVC before it reaches the earth's surface. UVB causes sunburn and skin cancer and is further potentiated by UVA.^{5,6}

Acute Sunburn Reaction • The acute sunburn reaction is very complex and involves a variety of biochemical pathways including histamine, kinins, and the prostaglandin cascade.⁷ Nonsteroidal anti-inflammatory agents such as aspirin, indomethacin, and ibuprofen, agents which irreversibly block the key enzyme in the prostaglandin synthesis pathway, cyclooxygenase, can decrease UVL erythema provided the irradiation coincides with peak blood levels of the drug.⁸ Other anti-inflammatory agents such as the corticosteroid have practically no effect by themselves on sunburn erythema.⁹

A hallmark of the acute sunburn reaction is formation of a dyskeratotic epidermal cell called the sunburn cell (SBC). These cells appear in the epidermis within 24 hours of UVL irradiation in a dose related fashion.¹⁰ They are produced by the UVB portion

of the spectrum which is thought to be responsible for carcinogenesis.¹¹

Sunscreen Usage • Sunscreens greatly diminish formation of SBCs in human skin,¹² and an important consideration is the in sun-protective-factor (SPF). This can be defined as the amount of UVL required to produce erythema in skin pretreated with sunscreen divided by the amount of UVL required to produce erythema in an untreated site.¹³ The SPF typically varies from 1 to 15. (The FDA has arbitrarily established an SPF of 15 as the ceiling.) A sunscreen with a factor of 1 offers the least protection while another with a factor of 15 offers the most protection, allowing an individual to receive 15 times the amount of sun he could normally tolerate without a severe burn. Those with higher factors also reduce the number of epidermal SBCs.¹⁴ Sunscreens can also prevent UVL induced changes in epidermal DNA synthesis.¹⁵

Sunscreens function by selectively absorbing various wavelengths of the electromagnetic spectrum within the ultraviolet portion. The major ones may contain para-aminobenzoic acid (PABA) and its esters, benzophenone, or cinnamates, either alone or in combination. PABA was recommended as a sunscreen as early as 1928.¹⁶

Some sunscreens with a low SPF, that is a lesser amount of UVL protection like PABA, allow tanning by allowing UVA to pass while absorbing large portion of the UVB.¹⁷ Other compounds such as the benzophenones block out mainly the UVA portion and smaller portions of UVB.¹⁸ A combination of a benzophenone and PABA ester may selectively block out large portions of both UVA and UVB allowing no tanning nor burning, and decreasing SBC formation.¹⁹ In a previous study, a PABA ester and benzophenone performed much better than all agents tested.²⁰

Patient Education • It is likely that the less exposure one has to UVL the less likely is the possibility of developing cutaneous neoplasia. As physicians, it is our duty to educate the public regarding photoprotection. The judicious and constant use of a sunscreen not only prevents the discomfort of an

acute sunburn but may also prevent premature aging of the skin and the different types of skin cancer. It is not unusual for the Florida dermatologist to see severe actinic damage and cancer, including malignant melanoma, in increasing numbers in younger members of the population. This knowledge is of prime importance to all Florida physicians since most of our patients can be advised or cautioned regarding the acute and chronic effects of sunlight, and the uses of sunscreens. Ideally, the use of a sunscreen should be part of one's daily routine just as is shaving and showering.

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Sorbitol accumulation in human normal and diabetic platelets

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ABSTRACT: Although most authorities suggest that there is a definite link between the vascular complications of diabetes and its metabolic abnormalities, the pathogenetic mechanisms of such a link remain speculative. Abnormal platelet function has been related to complications as has the accumulation of sorbitol in certain tissues. In this study, we evaluate the possibility that sorbitol may accumulate in the platelet of the diabetic patient and contribute to its abnormal hyperaggregability. We demonstrate that sorbitol does accumulate in the normal platelet incubated in high glucose media and that this accumulation can be blocked by an aldose reductase inhibitor. We also found high platelet sorbitol levels in poorly controlled diabetics with vascular complications. However, we could find no correlation between intraplatelet sorbitol levels and either platelet ultrastructure or function in normal or diabetic patients.

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The exact pathogenesis of the predisposition to thrombosis and atherosclerosis in patients with diabetes mellitus is unknown. Both of these processes are intimately involved in development of the macrovascular complications of the disorder and microvascular thrombosis has a significant role in development of the small vessel complications which are the hallmark of the disease. Most authorities suggest that there is a definite link between the metabolic derangement and the vascular sequelae.¹⁻³

Abnormalities of platelet function have been demonstrated in diabetes and in some instances were related to complications.⁴⁻⁶ The role of the platelet has assumed even greater importance with the realization that it is not only relevant to thrombosis but also to the development of atherosclerosis.⁷ Despite these important findings there is little to relate abnormal carbohydrate metabolism to platelet hypersensitivity in diabetes.

Sorbitol accumulation in various tissues such as nerve^{8,9} and the ocular lens¹⁰ are believed to contribute to the development of complications in these tissues. If similar sorbitol accumulation occurred in the platelet, this might result in abnormalities of platelet function with the subsequent development of complications. In the present paper, we present the results of a study to evaluate this possibility.

Patients and Methods • The patients were ten insulin-dependent diabetic men with age range of 26 to 45 years. All had significant clinical complications, i.e., retinopathy, peripheral vascular disease and neuropathy, and four were studied during hospital admission for uncontrolled hyperglycemia. The normal controls were four healthy males, age range 22 to 36

years, with normal two hour postprandial blood glucose levels.

Sorbitol Measurement • Platelet rich plasma was prepared from citrated venous blood by centrifugation in the usual manner and the platelet count was standardized by dilution to approximately 300,000 platelets per ml. After washing once in acetate buffer, a platelet button was prepared and resuspended in the buffer with adjustment of pH to 5.1. After addition of 3,0 methylglucoside as standard, the suspension was incubated for five minutes at 35C with glucose oxidase in an amount sufficient to oxidize the known concentration of plasma glucose. Six percent trichloroacetic acid was then added to precipitate protein and after centrifugation the supernatant was passed over a mixed ion exchange resin (20-50 Mesh AG 501 x Biorad.). Trimethylsilyl (TMS) esters of the alditols remaining were prepared by incubation in Tri-Sil 'Z' (Pierce Chemical Co.) and separation and estimation of these esters were performed using gas liquid chromatography as previously described.¹¹ The instrument used was a Packard Model 417 with hydrogen flame ionization detector. The 6' long ¼" diameter glass column was packed with 3% SE 52 on 100/120 Supelcoport and the injected sample was run in a temperature program from 140-260C.

In our initial experiments, platelet sorbitol levels were determined in normal platelets before and after incubation in glucose. Incubations were also carried out in the presence of an uncompetitive inhibitor of aldose reductase (E.C. 1.1.21) to evaluate the effects of such an agent on sorbitol accumulation. The agent used was the sodium salt 1,3-dioxo-1H-benz (de) isoquinoline 2(3H) — acetic acid (alrestatin, AY 22, 284) 50 mg/ml solution kindly provided by Ayerst Research Laboratories. In subsequent studies sorbitol levels were determined in the platelets from diabetic patients. All levels were then compared to various parameters of platelet function and structure (see below) performed on the same platelets. Plasma glucose levels were measured by the glucose oxidase technique using a Beckman glucose analyzer.

Platelet Function and Structure • ADP-induced platelet aggregation was performed by the Born technique¹² using a Biodata PAP-3 aggregometer. Percent aggregation at four minutes after addition of 1 umol ADP was recorded. Spontaneous platelet aggregation after 11 minutes of stirring without addition of aggregating agents was also evaluated.

The platelet aggregate ratio,¹³ a simple method of determining circulating platelet aggregates, was also performed. After fixation of platelets in glutaraldehyde, platelet ultrastructure was also assessed by electron microscopy.

Results • Table 1 shows the sorbitol levels determined in normal platelets before and after incubation in various final concentrations of glucose. The effects of addition of the aldose reductase inhibitor (ARI) are also shown. Although no sorbitol was detectable in platelets without added glucose, there was a significant accumulation in the platelets incubated in high glucose media and this was effectively blocked by the aldose reductase inhibitor. As is also shown, ADP induced platelet aggregation showed no significant differences between any of the platelet samples. (In a separate experiment, incubations of platelet-rich plasma in sorbitol solutions of varying concentrations (10 mM-2M) resulted in no significant change in platelet function.)

Table 1. — Platelet Function and Sorbitol Content — Normal Platelets Incubated in Glucose With or Without Aldose Reductase Inhibitor (AY 22, 284).

PRP — Final Glucose Conc. mmol/l.		None Added	16.7	27.8	33.3
Without AY 22, 284	Sorbitol umol/ml	ND	0.023	0.375	0.421
	% Aggregation *	6	5	8	9
With AY 22, 284	Sorbitol umol/ml	ND	ND	0.002	0.001
	% Aggregation *	7	5	8	5
* 1 umol ADP at 4 min.		ND = Nondetectable			

Table 2 shows the sorbitol content of platelets from four poorly controlled diabetics demonstrating an increase in sorbitol levels with increasing blood glucose. In Table 3, the levels of platelet sorbitol in six diabetic patients are compared to the results of platelet aggregometry and the platelet aggregate ratio on the same platelets. No significant correlations were found.

Table 2. — Sorbitol Content of Platelets — Poorly Controlled Diabetics.

Glucose Conc. mmol/l.	16.0	20.5	31.3	34.0
Sorbitol Conc. umol/ml	0.09	0.13	0.36	0.36

Electron-microscopic examinations of platelets from normals before and after incubation in high glucose media (with demonstrated sorbitol accumulation) revealed no significant ultrastructural changes.

Discussion • The human platelet possesses active carbohydrate metabolic pathways which are responsible for the majority of energy production with the

cell, predominantly via the Embden-Meyerhof pathway. The glycolytic rate of platelets with added glucose is about 13 times that of the red cell.^{14 15} In such a cell, it would not be unreasonable to surmise that the alternative pathway of sorbitol metabolism might be present and that this pathway might be particularly active under conditions of hyperglycemia and insulin deficiency or insensitivity. Although the platelet has been shown to possess insulin receptors,¹⁶ like the red cell it may have the ability to transport glucose by insulin independent pathways under conditions of severe hyperglycemia.¹⁷ From our results, it would appear that this is the case. However, despite significant sorbitol accumulation in normal platelets incubated in glucose and also the demonstration of its presence in platelets from diabetic patients, we were unable to demonstrate any significant correlation with abnormal platelet function or structure in this preliminary study.

Table 3. — Platelet Function and Sorbitol Content — Diabetes.

Patient	1	2	3	4	5	6
Sorbitol $\mu\text{mol/ml}$	0.01	0.01	0.81	ND	0.02	0.28
% Aggregation *	3	22	30	100	72	4
PAR † ($N = 0.86 \pm 0.02$)	1.00	0.94	0.64	0.94	0.90	0.82
Spont. Agg. ‡ (11 min.)	Neg.	Neg.	Neg.	Pos.	Neg.	Neg.

* μM ADP at 4 min. ND = Nondetectable

† PAR = Platelet Aggregate Ratio

‡ Spont. Agg. = Spontaneous Aggregation

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Hope for Haiti

Robert D. Carraway, M.D.

Maladi gate' vâya.

Illness spoils the most valiant.

— **Creole proverb**

Few days pass when one does not read accounts of Haitian refugees landing on Florida's shores. All too often such accounts relate tragic endings for individuals who attempt to make this 700 mile voyage in small and overcrowded boats. Florida physicians have felt the impact as well, for many have been called upon to treat the refugees who are often afflicted with malnutrition, tuberculosis and other infectious diseases. Despite changes in government policies, the Haitian dilemma is not likely to disappear.

Recently I was able to experience the internal problems of Haiti as a physician volunteer at the Hôpital Albert Schweitzer, providing me with insight into at least one area of positive action in a country whose problems seem insurmountable.

Republic of Haiti • "Haiti" comes from the aboriginal Arawak Indian word meaning "mountainous country." It lies in the western third of the island of Hispaniola which is shared with the Dominican Republic. Haiti has an area of 10,714 square miles, about the size of the State of Maryland. Its population is estimated to be 5 million — nearly all of whom are descendants of African slaves giving the nation a density of nearly 500 persons per square mile. However, since two-thirds of the land area is covered by mountains rising to nearly 9,000 feet, the remaining one-third of the country provides living space for its population and this resulting habitable land is thus densely populated.

The Author

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Haiti's weather is much like that of South Florida. It too has a wet and dry season and during the former, torrential rains can occur with short notice.

**The official language is French
but it is spoken by only 10 to
15% of the population.**

The official language is French but it is spoken by only 10 to 15% of the population. The peasant speaks Creole, an amalgam of French, English, Spanish and African languages. Illiteracy approaches 85%.

Haiti has been said to be the poorest of the nations in the Western Hemisphere with a per capita income of \$230, or less than three percent of the American per capita income. An average wage for a day laborer is less than two dollars per day. Unemployment is very high, especially in the cities.

History • Haiti has had a colorful but stormy history. It was discovered by Columbus in 1492 who returned to establish the first permanent settlement in 1496. The country was first colonized by Spain and the peaceable and tractable Arawak Indians would soon be enslaved by their Spanish masters and then die in increasing numbers. They endured this captivity poorly and the native Indians were nearly exterminated. To maintain an adequate labor force the Spanish colonialists and later the French turned to importing African slaves to replace the ever dwindling Arawak Indian population. By 1791 the slave population was about 500,000. Sparked by news of the French Revolution, a rebellion occurred amongst the slaves that led to a declaration of independence by Pierre-Dominique Toussaint l'Ouverture in 1801. Napoleon Bonaparte attempted to regain Haiti under the command of his brother-in-law, General Leclerc. Guerilla warfare and yellow fever, of which Leclerc would die, took its toll and in 1804 Jean-Jacques Dessalines won independence and gave the new nation its aboriginal name Haiti.

Haiti's prior prosperity, which had been so great that its imports and exports were said to exceed that of the 13 American colonies, would suffer in the years ahead. There occurred over 100 civil wars, revolutions, revolts, coups and assassinations. In 1915 the American government sent U.S. Marines to establish a military protectorate which would rule for nearly 20 years. Progress was made during these years to improve roads, communications and sanitary facilities. The occupation also helped to give Haitians a taste of American life.

Francois Duvalier came to power in 1957 and later would have himself proclaimed "president-for-life." At the age of 19 Duvalier's son, Jean Claude or "Baby Doc", succeeded his father upon his death in 1971. In recent years there has been some relaxation of the police-state tactics of "Papa Doc" and more liberal policies are at times evident.

Health in Haiti • As many Florida physicians have come to experience personally, Haitians are plagued by malnutrition and all forms of infectious diseases. It is no wonder that life expectancy is only 47 years. The Government spends 11% of its budget for health,¹ but this translates to less than \$10 per person per year. Most physicians are located in urban areas so that in many rural parts there may be only one physician per 70,000 persons.

Haiti's only medical school is at Port-Au-Prince and graduates more than 100 physicians per year. After formal training each physician is obligated to serve two years in government service and then many make plans to leave for the United States or for French speaking parts of Canada.

Folk medicine is still a vital element in Haitian life.

Folk medicine is still a vital element in Haitian life. The Bôcor or witch doctor is often the first line of therapy, especially for the peasant. Only after precious time is lost and the patient has significantly deteriorated will the Bôcor admit his failure to heal and the desperately ill patient is then sent to a medical facility.

The Mellon Mission • Reading a copy of *Life* magazine, William Larimer Mellon learned of the work and dedication of Albert Schweitzer in Africa. Mellon at this point decided that he should follow Schweitzer's example.² Dr. Mellon had been influenced by his mother who was deeply religious, gentle and modest; in his youth she had told him that the greatest thing that he could do would be to be a medical missionary.³

At the age of 39 he entered Tulane's School of Medicine despite discouragement from friends and faculty members who felt that he was too old to embark upon a career in medicine. He had married the former Gwen Grant who fully endorsed his idea and entered school herself to become a laboratory technician.

During the medical school years the Mellons visited with Schweitzer at Lambare'ne' in 1951 and worked with lepers. Dr. and Mrs. Mellon were able to observe the operation of Schweitzer's hospital and would later incorporate many of his principles in their own hospital and work.

While in the third year of medical school Dr. Mellon traveled to Haiti to obtain information for a thesis on tropical ulcers. He visited the Artibonite Valley and discovered an area of great medical need. He obtained 100 acres of land from the government for the site of the hospital. The Grant Foundation was then established to finance the construction and operation of the proposed hospital. Construction was started before he had finished his medical training and a staff was actively recruited while construction proceeded. In June 1956 this modern \$1.5 million facility was dedicated to serve over 120,000 people who had previously had only the most primitive medical facilities.

(Dr. Mellon) established a beef and poultry farm along with a dairy . . . These projects provided the necessary food for hospitalized patients.

During the early years of the hospital's operation Dr. and Mrs. Mellon worked within the hospital to ensure its successful development. However, Dr. Mellon quickly realized that the valley people required more than just medical attention to improve their lives. He became increasingly involved in non-medical programs and established agricultural and irrigation programs to improve the yield of the land. Having owned and operated a large ranch, he established a beef and poultry farm along with a dairy. Besides providing employment, these projects provided the necessary food for the hospitalized patients and staff. A veterinary clinic was established to support the farm activities. Local craftsmen were encouraged by the establishment of a woodworking, ceramic and weaving facility which sold their products in a boutique on the hospital grounds as well as to shop owners in the States. In addition to improving irrigation in the area, he undertook a well digging project to ensure new sources of water which was then piped from the mountainside wells and springs to the valley below.

Artibonite Valley • This broad basin is situated in the middle of Haiti and is nestled between two mountain ranges with peaks rising nearly 6,000 feet. Extending from the Artibonite River are multiple canals which serve to irrigate the valley floor. This irrigation system was originally begun under French occupation and was extensively improved during the period of American control. However, because of political differences between Haiti and the United States the full project was never brought to fruition. Thus, this potentially fertile valley fails to yield its full harvest not only because of limited irrigation, but also because agricultural techniques are primitive and fertilizer is too expensive to purchase.

The people of the valley are farmers and peasants who grow rice and corn and harvest the bananas, limes, mangos, oranges and grapefruit that grow readily in this area. Their rugged and muscular frames belie the pervasive malnutrition that probably contributes to their small stature. They are a friendly, docile, meek and affable people. There is resignation to their simple life and its tragedies. Few opportunities are available to the area youth, many of whom go to Port-Au-Prince seeking the opportunities of a city, only to join the large numbers of unemployed.

Animals are seen everywhere, especially chickens, mules, horses, goats and pigs. Interestingly, animals with less utilitarian value such as dogs and cats are less common. The animals also appear undernourished and often sickly.

Electricity is limited to the main road and telephones are essentially nonexistent. Private cars are rare, and transportation is by foot, mule, horse or the colorful camion which is a brightly painted vehicle often bearing a catchy slogan and usually fully loaded with people, chickens, pigs, corn and other produce on its way to the local markets. The camion industry forms a major segment of private enterprise in Haiti.

The similarity to the African countryside is striking . . . not a few African nations enjoy considerably more prosperity than Haiti.

The similarity to the African countryside is striking. The small mud huts with thatched roofs that house whole families, the women carrying large loads upon their heads over small winding paths, and the open air markets where individuals gather to buy and sell their produce, all reflect the African heritage. The standard of living is also similar to many African states and not a few African nations enjoy considerably more prosperity than Haiti.

Hôpital Albert Schweitzer • It is felt by some that Hôpital Albert Schweitzer (HAS) provides the best medical care in Haiti. This 150 bed facility of which 105 beds are for acute care, provided 50,000 inpatient days of medical care in 1980. The remaining 45 beds are divided between 15 isolation beds for active tuberculosis, and 30 beds for nutritional rehabilitation after the acute phase of malnutrition has been treated. A short distance from the main hospital is another 41-bed facility established by members of the HAS staff for tuberculous patients who are no longer in need of acute hospital care. This facility is located on a separate, isolated compound that permits patients to walk freely out-of-doors for exercise and recreation.

A registered nurse receives a monthly wage of \$210 plus housing, while a physician starts a \$666 per month plus housing.

The acute care beds are located in a large concrete building with high ceilings and expanses of open windows to provide maximum ventilation and cooling. This building forms one side of a square courtyard around which the laboratory, central supply and administrative offices are located. In the center of the courtyard lies a fountain and reflecting pool with a plaque which commemorates Albert Schweitzer. Throughout the hospital several large photographs of Schweitzer are found which depict various aspects of his life and work. This central courtyard is the frequent site of the pediatric clinic where the physicians work under the large overhanging roof which protects them from the sun but allows them to work in the open air. Another adjacent large courtyard provides space for health education classes and tuberculosis clinics.

The HAS grounds provide a campus-like environment. Many of the buildings are constructed of stately fieldstone, placed on large lawns, and nestled beneath huge poinciana trees that provide cool shade. Interiors feature mahogany paneling and handsome open beam ceilings. In all, some 60 buildings are situated over a gentle rolling hillside and form a self-sufficient compound with its own electricity, stores and recreational facilities that include a tennis court and swimming pool.

There is a two-room air conditioned surgical suite. The radiology department is equipped for basic procedures such as upper gastrointestinal series and intravenous pyelograms. These are read by the individual staff physician unless a visiting radiologist is present. The pharmacy and clinic occupy a common area and served more than 63,000 outpatients in 1980.

The hospital provides more than medical care. It is the largest single industry in the area, employing over 300 persons, and it is vital to an economy where a daily wage is less than \$3.00. A registered nurse receives a monthly wage of \$210 plus housing, while a physician starts at \$666 per month plus housing.

Hospital Staff • One of Dr. Mellon's objectives is to obtain a basically Haitian staff. There are seven full-time Haitian physicians and several Haitian nurses. Foreign volunteers come regularly to the hospital and offer their separate skills. Yale University has had a long standing program which provides a rotation through the hospital for its third and fourth year surgical and ophthalmology residents. The Yale surgical resident forms a team with two Haitian surgeons. Unlike many rural and missionary hospitals, HAS has always been specialty oriented. Medical services are divided among the surgical, medical and pediatric services, each of which has three physicians. All eye problems are referred to the ophthalmology resident whose rotation is arranged to give the hospital continuous ophthalmology coverage. There is a Community Health director who directs five outlying dispensaries which handle about 60,000 patients per year. These dispensaries are run by paramedical personnel trained by the hospital. The community must provide and maintain a building which serves as a clinic.

Obstetrical care is still done at home. An early determination was made that if routine obstetrical care was done at the hospital, the facility could be quickly inundated with this service alone. Complicated obstetrical problems are handled by the surgical department and such conditions as preeclampsia become the responsibility of the medical service. Cesarean sections are avoided whenever possible because of the risk of unattended future deliveries. Prenatal care is provided by an obstetrical clinic which is administered by nurses. It is not unusual for a newborn infant to be brought to the hospital for cord cutting which has reduced neonatal tetanus.

Volunteers are attracted from many countries and create an international atmosphere. Recently individuals from Canada, the United States, Belgium, Switzerland and Holland were in residence. The Mennonite Church has had a long and successful cooperative program with the hospital, providing needed volunteers who come for 30-month rotations. They serve in nursing, laboratory, secretarial and administrative positions. A teacher provides education for the staff children in the hospital school where a curriculum is offered in French and English. Still, the vast majority of technical and nontechnical personnel are Haitian individuals, many of whom have grown up in this area and now serve their people through this facility.

Educational Atmosphere • A definite educational atmosphere is present at the hospital. There are regular staff conferences which at times are conducted by visiting physicians who have academic credentials. An excellent medical library exists with a complete inventory of basic textbooks, some journals and an extensive reprint file. For the volunteer there is the opportunity to see diseases which he may have only read about and much time is spent in the library reviewing these entities and learning from the Haitian physicians whose experience in these clinical situations is often substantial. The long-standing contact with Yale University helps foster this educational atmosphere. An estimated 50 papers have originated from the hospital.⁴

For the volunteer there is the opportunity to see diseases which he may have only read about . . .

Autopsies are encouraged and each physician performs his own examination with the aid of an experienced assistant. Results are then reviewed at a mortality conference. Permission for autopsy is usually easily obtained from the family. In an area of increased superstition, where Voodoo is prevalent, it was explained by a Haitian physician that some local peasants believe that the autopsy destroys the residual life force of the individual and ensures that the deceased will not return as a zombie.

The hospital is definitely isolated and such isolation encourages many staff social functions. The swimming pool is a favorite gathering place on weekends and there is the tennis court, horseback riding and mountain climbing. A beautiful sandy, isolated beach is only 20 miles from the hospital, but because of the poor roads it is an hour trip. The water is clear, inviting and contains excellent reefs for easy snorkeling in water from 5 to 30 feet deep.

Medical Practice at HAS • Clinical problems in Haiti are substantially different from even those seen in the subtropical areas of Florida. Also, more common entities such as tuberculosis present with manifestations which are seldom seen in the United States.

Medicine: Tuberculosis has been a widespread problem in Haiti and it is estimated that about three percent of the population was actively infected which made the incidence of this disease one of the highest in the world. Virtually the entire adult population has a positive PPD. After only several weeks as a volunteer, an internist may see nearly the entire spectrum of tuberculosis: cervical adenitis, tuberculous pericarditis which may present as congestive heart

failure and impending tamponade, Potts disease, tension pneumothorax, tubercular uveitis.

Interestingly, there appears to be less than the expected incidence of renal tuberculosis. Therapy includes isoniazid thiacetazone and streptomycin initially. The use of thiacetazone for tuberculosis was first reported in 1946. Initially the incidence of toxicity made the agent unacceptable. It was again restudied in 1957 with lower doses being used and its effectiveness was comparable to isoniazid and PAS. The combination of 150 mg. of thiacetazone and 300 mg. of isoniazid is marketed as a medication called Thiazina which is an agent which permits simple one tablet dosing per day and provides improved keeping properties in tropical areas.

Thiazina's low cost, single daily dose and limited toxicity makes it a first-line medication for tuberculosis in many Third World areas. In general, the patient with advanced tuberculosis is treated with triple therapy usually as an inpatient for 4-8 weeks and then is discharged to be followed as an outpatient on Thiazina for a total period of usually 24 months.

During the rainy season patients frequently present with lethargy, disorientation and coma . . . the most likely diagnosis is cerebral malaria.

Rainy Season • During the rainy season patients frequently present with lethargy, disorientation and coma. In such an individual, the most likely diagnosis is cerebral malaria. *Falciparum* malaria in this advanced stage carries a high morbidity and mortality. Therapy with parenteral chloroquin is often dramatic, however. The patient may be alert and oriented in as little as 12 hours after initiation of therapy. During the malaria season, patients who present with headache, chills and fever, a negative malaria smear and no obvious etiology for these symptoms, are routinely treated for malaria, usually with excellent results.

Tetanus is common in infants, children and adults alike. An extensive immunization program has provided a substantial drop in incidence and mortality within the hospital district.⁵ Still there is a high incidence outside the hospital district and these patients come from long distances to be treated. There is a strict protocol for therapy which is supervised by the anesthesia department. The hospital's mortality rate compares favorably with that reported from other facilities.

Typhoid fever is frequently seen and the patient commonly presents in a very toxic condition. At times generalized peritonitis is the presenting complaint secondary to an intestinal perforation. Typhoid

fever is therefore always considered in the differential diagnosis of an acute abdomen.

Anemia Is Common • Anemia is commonplace and it is remarkable how well it is tolerated by some individuals. The etiology is complex but malnutrition, iron deficiency and gastrointestinal blood loss secondary to parasitic infestation, all may be contributing factors. Severe anemia may present as congestive heart failure, syncope, and "watery menses." Hemoglobins of 2 or 3 are not unusual and these patients are treated with blood transfusions followed by evaluation for parasitic infestation and correction of dietary factors. A simple approach is necessary in place of the bone marrow, B-12 level and colonoscopy that might be considered in a more developed nation.

Resources at the hospital are limited and laboratory evaluation must of necessity be held to a minimum. This places an increased stress upon the physical examination and clinical judgment of the physician as the history is often unreliable and the laboratory studies are limited. One must also consider the cost of therapy. Favored pharmacologic agents are often not available or too costly for routine use. One must depend heavily upon donated items. All such donations are welcomed since the hospital's annual budget is \$1.1 million and only 12% of this amount is obtained from patient fees. The remaining funds are supplied from the Grant Foundation and individual donors.

Pediatrics: A major problem for this service is the large number of infants with diarrhea and dehydration. In addition to the inpatient pediatric ward, there is an overnight ward for short term rehydration by oral and parenteral means for this condition. On a busy night up to 80 infants crowd a relatively small area which is staffed by the pediatrician on call and several nursing staff members.

. . . it is estimated that 26% of Haitians between the age of three months and 59 months are stunted secondary to nutritional deficiencies.

Malnutrition is another common problem as it is estimated that 26% of Haitians between the age of three months and 59 months are stunted secondary to nutritional deficiencies.⁶ The hospital operates a 20 bed acute care unit for infants and children who are acutely ill for malnutrition and a 30 bed unit for nutritional rehabilitation after the acute phase has been successfully treated. Both kwashiorkor and marasmus are frequently seen. It can be frustrating to deal with malnutrition since after treatment a child may

return home with food supplements, but upon returning to the prior environment, the condition may again repeat itself.

Despite the adage that acute rheumatic fever is seen less frequently in the tropics, this entity is by no means rare. Rheumatic valvular heart disease is seen in the older age groups and it is frustrating to see children and young adults with correctable valvular lesions, but no available facility for cardiac surgery.

Surgery: Burns are not infrequently seen at the hospital because there is no electricity and the use of open fires is prevalent for the cooking of meals. Children are left at home at times with smoldering fires which can turn into a major blaze resulting in serious injury. Occasionally epileptic patients are brought to the hospital after falling into a fire during a seizure. The incidence of peptic ulcer disease appears to be increased in this area. A frequent complication is a gastric outlet obstruction and surgical relief is often mandatory.⁷

Lip Laceration Syndrome: A challenging surgical problem seen from time to time might be called the "elliptical lip laceration syndrome." A woman presents with ragged laceration of her lip which may come close to an amputation of the involved tissue. The surgeon must use appropriate skill to save the tissue from devitalization and to minimize subsequent scarring. The bite of another woman is the etiology of the laceration. Usually the attacker is avenging herself for the victim's indiscretion with a boyfriend or husband.

As noted before, obstetrical complications are handled by the surgical service and ectopic pregnancies with intra-abdominal hemorrhage and shock is one of the more common problems. Trauma and fractures are also common but more complicated orthopedic problems are reserved for a visiting orthopedic surgeon who comes to the hospital several times a year. Tuberculosis of the spine provides one major element of his work load. A thoracic surgeon also periodically visits the hospital. As expected, tuberculosis is a leading cause for the need of thoracic surgical intervention.

Ophthalmology: A frequent eye problem is corneal ulceration which results from corneal trauma

that has been left untreated. Keratomalacia due to Vitamin A deficiency is seen not infrequently. If untreated, it may result in perforation and iris prolapse with loss of sight.⁷ Glaucoma appears to occur with an increased incidence and is frequently resistant to therapy even if the patient is conscientious in using his eye drops. Cataracts are common and perhaps start at an earlier age. Cataract extraction is the most common ophthalmologic procedure at the hospital.

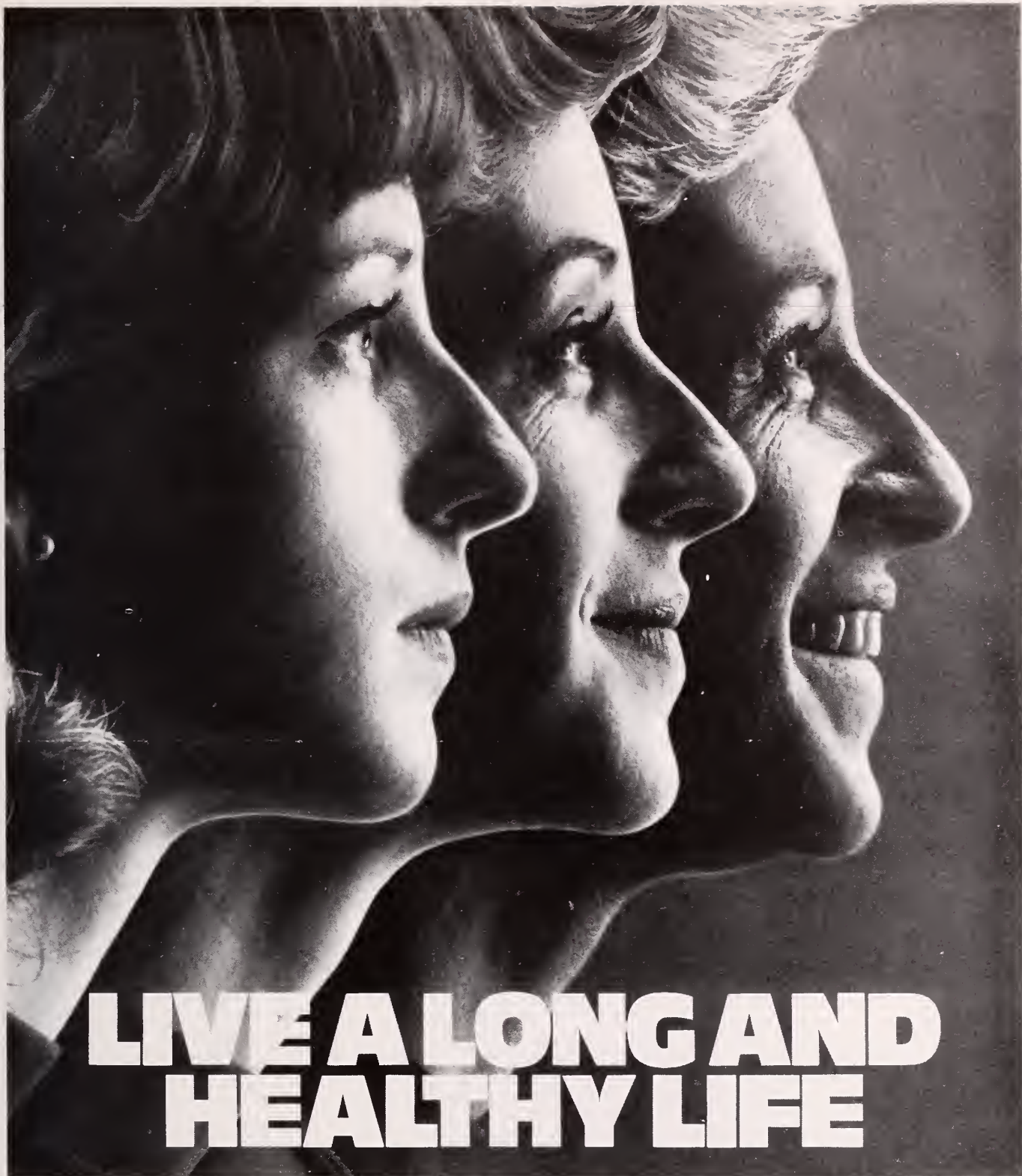
Cataract extraction is the most common ophthalmologic procedure at the hospital.

Future Directions: The transition to a fully Haitian staff is an important priority. While the present staff is becoming more self-sufficient, volunteer workers and donated resources are vital assets. A new full-time hospital administrator from Canada, William Jackson, will attempt to unify the direction and operation of the hospital by assuming functions of several persons who shared in these responsibilities. Dr. Muller Garnier is leaving after spending eight years as the medical director and 17 years as a staff physician, a period of time second only to that of Dr. Mellon himself. Dr. Garnier's experience and leadership will be hard to replace.

Nonetheless, HAS will continue to respond to Schweitzer's plea. "Help life wherever you find it." In so doing, it will continue to foster hope for Haiti.

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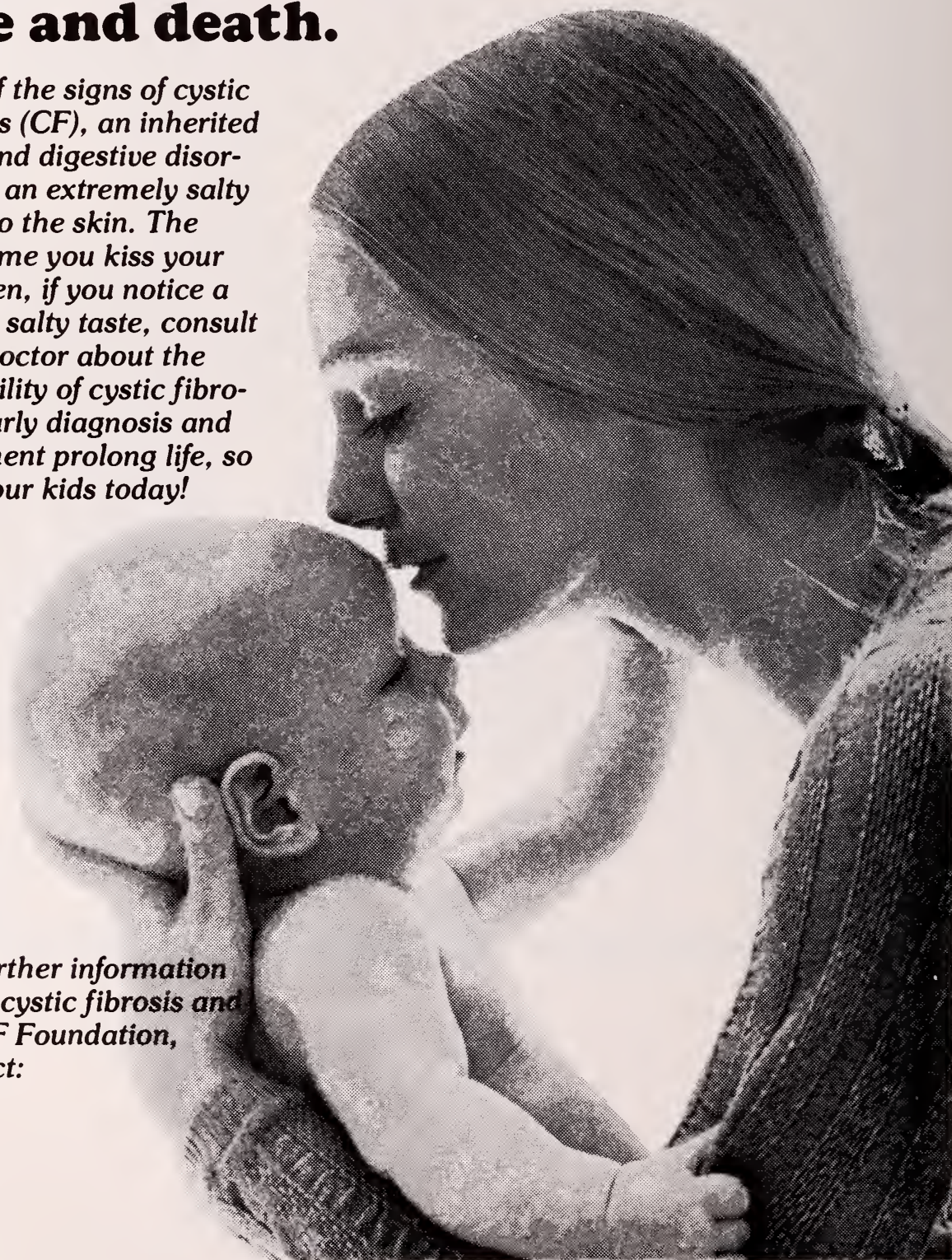
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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.¹

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.²

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.³

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, light-headedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdose, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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FLORIDA MEDICAL DEPARTMENTS

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NOTES & NEWS

New division chief at UF

Robert Whitney Curry, M.D., has been named Chief of the Division of Family Practice at the University of Florida College of Medicine.

A Diplomat of the American Board of Family Practice and the American Board of Internal Medicine, Dr. Curry's responsibilities will include the training of family physicians through a three-year residency program operated in cooperation with Alachua General Hospital.

For the past five years Dr. Curry has been Assistant Professor of Family Practice and Director of the Inpatient service.

A native of Bradenton, Dr. Curry received his M.D. degree at Duke University Medical School in 1971.

PA program at UF funded

The University of Florida's fiscally foundering physician assistant program has received money to assure its continuation.

The 1982 Florida Legislature earmarked \$98,000 to support the two-year training program during the 1982-83 academic year, and the U.S. Department of Health and Human Services has extended its grant of \$178,000 to help finance the program through its 11th year of federal funding.

The University has been notifying more than 400 prospective applicants that the program is continuing. Only 30 students are enrolled each year.

Florida's Board of Regents has approved the transfer of the program from the College of Medicine to the College of Health Related Professions. The University of Florida program is the only one of the nation's 53 physician assistant curricula located in Florida.



Sanford A. Mullen, M.D. (left), Immediate Past President of FMA, presents to Mr. Ney C. Landrum, Director of the Florida Division of Recreation and Parks a plaque commemorating the achievements of the late Dr. John Gorrie. Dr. Gorrie was noted for his work to find a cure for yellow fever and malaria and for his invention of an ice-making machine. Plaque was presented on April 28 at the Gorrie Museum at Apalachicola.



WORTH REPEATING

Thoughts on the legislative process

Having just returned from a week spent with our legislators and lobbyists in Tallahassee, there are several impressions I would like to pass on to the membership.

Our medical lobbyists are tops in their fields, well respected in the legislative corridors, and work with zeal to represent our best interests. Under great pressure — sometimes from us whom they recognize to be the "bosses", frequently from the legislators themselves, but mostly from the moment by moment ever-changing sequence of events, they manage to submit suggested amendments, testify to committees, lobby to convince the individual legislators of the "rightness" of our position, match political wits with our opponents, and still maintain the decorum and sense of balance necessary to reflect positively on our profession.

It was again brought home that the individual physician, because of community standing we have all collectively earned, has great potential in effecting legislation. Warmly received by every one of our representatives and senators, we were heard attentively (and most positively) on many issues and in

several instances able to see these discussions translated into active support of the medical position in committee and on the floor. Never underestimate the power of your individual involvement — by telephone, telegram, letter, or personal contact. You *can* do something about what goes on in Tallahassee and Washington!

Lastly, we must not become "one issue" oriented in the political process. A legislator who has opposed us in one area sponsored an FMA amendment and successfully changed a bill in committee to our position, finding support from another of our legislative delegation who has also supported us in most of our concerns, but opposed us in a completely different area. We must look at the legislator's overall voting record — his percentage of support — and not fall into the trap of expecting full support on every issue. As we continue to make our presence and opinions felt in the halls of Tallahassee and Washington, we must maintain maturity in the political process — supporting those who support us, opposing those who generally oppose us — but realizing we are not the only constituents of any legislator, and that our own personal concerns are not the only concerns of medicine.

Thomas M. Daniel, M.D.
Clearwater

Reprinted from the *Pinellas County Medical Society Bulletin*.

Medical fraud and medical licensure

Michelle Labella graduated from the University of Rome School of Medicine in 1952 and practiced medicine in Italy until 1976, when he decided to relocate to the United States.

He settled in Florida and sat for the ECFMG (Educational Council on Foreign Medical Graduates) examination. However, he was not eligible to take the Florida Licensure Examination until he had either served an internship year, or could show proof of five or more years of active practice in any state or country in which he held a valid medical license. Since he was licensed only in Italy, he needed affidavits from three Florida physicians who would certify that he practiced there.

Through acquaintances in Dade County, Dr. Labella was introduced to several physicians who agreed to sign statements required by the Medical Board that would verify his practice in Italy. It was not mere coincidence that they, too, were Italian-born physicians who could be expected to be sympathetic towards his plight. Once they complied with his request, Dr. Labella was permitted to enroll in the University of Miami's ten month study course designed to prepare foreign medical graduates (FMGs) for the

Florida Medical Licensure Examination. He completed the course and passed the examination.

In 1978, Dr. Labella entered medical practice in Dade County. By December of that year, he visited the physicians who had verified his practice in Italy and presented each of them with a bottle of wine. He revisited one of the doctors in March of 1979 to request another letter of recommendation to support his application for staff privileges at a North Dade County hospital. The physician did so, and in his letter to the credentials committee wrote that "Dr. Labella is well-rounded medically, compassionate and has high ideals in the practice of medicine".

In early 1981, a story appeared in the *Miami Herald* that exposed Dr. Labella as a fraud: he was not an Italian physician, but a felonious pharmacist from Toronto who had fled Canada to avoid arrest on charges of trafficking in illegal drugs. He went to Italy where he assumed the identity of a deceased physician named Michelle Labella, and then obtained an entry visa to the United States. Once in the U.S., he studied for and passed the ECFMG exam, which requires only a modest amount of medical knowledge and just a basic understanding of the English language. Apparently, because he didn't want to risk the exposure of an internship year, he decided to find three sympathetic countrymen who would perjure themselves on his behalf.

Dr. Labella was arrested and extradited to Canada to face criminal prosecution. The three physicians who conspired with him, now face penalties for having violated Chapter 458 of the Medical Practice Act, which imposes sanctions against anyone who has "aided and assisted an unlicensed person to practice medicine; for using fraud and deceit to obtain a medical license; by being guilty of immoral and unprofessional conduct and by engaging in deceptive conduct harmful to the public".

The Labella case is over, but there is evidence that other Florida physicians have also used fraud and deception to obtain medical licensure. Other cases are now under investigation and several administrative complaints have already been filed by the Department of Professional Regulation (DPR) against physicians who obtained their medical licenses under false pretenses.

A large number of these physicians appear to be Cuban nationals, who came to Florida during the great exodus from the political persecution and economic upheaval that gripped their country after 1959. They were forced to flee quickly, leaving behind medical diplomas and other written documentation claiming they were graduates of Cuban medical schools and had practiced there for at least five years.

Outpourings of sympathy for their plight, and political pressure from the Cuban population, encouraged several Dade County lawmakers to write legislation which made it easier for the refugee physicians

to obtain their Florida medical licensure. So easy, in fact, that many individuals who had never even attended medical school were able to obtain a license.

All FMGs are obliged to provide a valid copy of their medical diploma, but the Cuban government's lack of cooperation forced the elimination of this requirement. All FMGs must pass the ECFMG, but this requirement was eliminated for Cuban doctors because of political factors in Florida.

All FMGs are required to serve either a 12-month internship or, in lieu of that, be able to prove five years of licensed, active medical practice anywhere in the world. Despite the latter requirement, it is unreasonable to expect that such practice prepares the FMG for the type of sophisticated medical practice that is required in Florida and other American states.

Proof of five years of active practice is provided via affidavits from three physicians. With these signed affidavits, the FMGs are then entitled to enroll in a special preparatory course formulated solely to help them pass the licensing examination — not guarantee their medical competence. The course has been given in either Spanish or English and, until 1980, was administered in both languages. All candidates for licensure by examination must now sit for the FLEX (Federation of State Medical Boards Licensure Examination), which is given only in the English language.

Another area for potential licensure fraud can be demonstrated by a recent case in which the DPR filed an administrative complaint against a Florida physician for taking a medical licensure exam in another state, for a relative. The fraud was discovered much later, and only because a complaint was filed against the physician by an informant.

I believe that severe deficiencies exist in a process that grants medical licenses to unqualified individuals who have used deceit and fraud, and that strong remedies are required to prevent further mistakes. Furthermore, all medical students should be fingerprinted as an entry check for all licensure and specialty examinations, and as a means of certifying the identity of the applicants. In situations where medical colleges do not cooperate with licensing authorities — for whatever reason — and do not provide an official notarized copy of a medical diploma, the applicant should be required to take a 12-month internship as a way of trying to guarantee his medical competence.

It should be obvious from the Labella case that physicians who perjure themselves to help a professional colleague, act as a destructive force for the entire credentials process and jeopardize a system which was designed to protect the public from incompetent medical practitioners. Physicians who commit perjury will continue to be charged with violations of the Florida Medical Practice Act.

All physicians should think carefully before providing references for any physician they do not know, or whose competence they doubt, even for admission to a local hospital's medical staff.

*Richard J. Feinstein, M.D.
Miami*

Reprinted from *Miami Medicine*, December 1981



THIS SPACE CONTRIBUTED AS A PUBLIC SERVICE

**Proceedings of the 1982
FMA Annual Meeting will be
published in the July issue.**

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussions of medical history and ethics; and articles dealing with socioeconomic, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to Daniel B. Nunn, M.D., Editor of *The Journal*, Florida Medical Association, Post Office Box 2411, Jacksonville, Florida 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

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Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

Abstract. All scientific manuscripts should include a 150 word, maximum length, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

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List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given.

References. The following minimum data should be given:

names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request".

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication".

When received, the senior author will be sent an acknowledgement of receipt and a copyright agreement which must be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

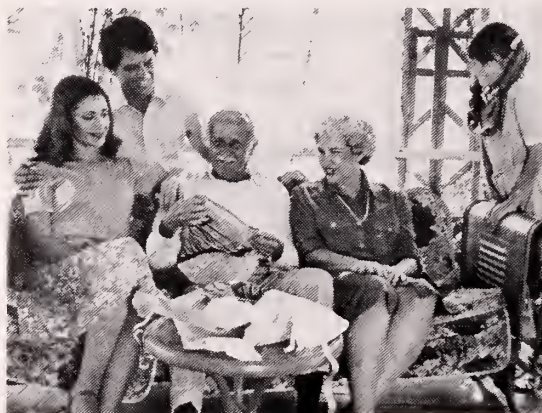
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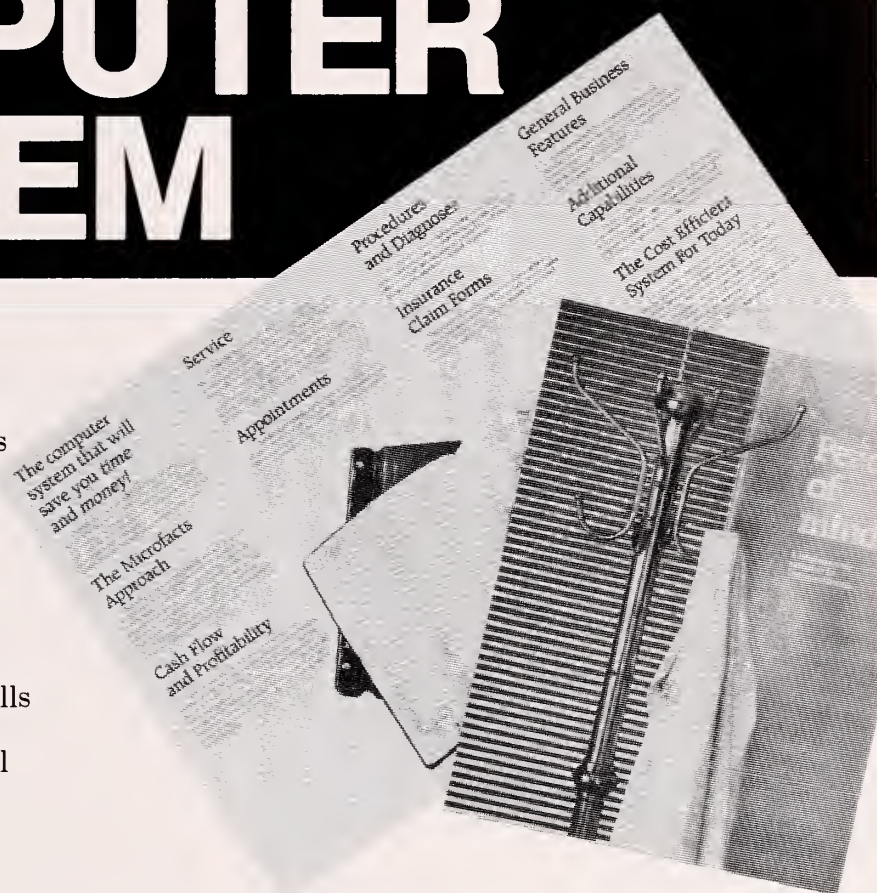
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Book Review Editor — **F. Norman Vickers, M.D.**

The hour of our death

By Phillipe Aries, 651 Pages. Price \$20.00. Alfred Knopf, New York, 1981.

Physicians have developed an increasing ability to prolong life and to prolong the act of dying. Because of this we have the need to make decisions regarding life and its continuation. We therefore need a solid perspective of the ethical, moral and religious, and psychological implications of death to the individual.

Philippe Aries' book is then an important contribution to the literature on death and dying. He views our attitudes on death in their historic perspective. He traces a series of changes that have occurred in our attitude toward death starting with our old attitudes with its roots in the Greco-Roman world. About 1000 A.D. these attitudes began to change, beginning with the "tame death" in which death is familiar and not frightening, and in which each life is secondary to the community. Following this there developed an awareness of each individual person and his relation to the afterlife.

Later in the 16th and 17th centuries attention swings from the death of the individual to the death of other persons, such as children and spouse, that makes the problem of separation a difficult one. Finally, in our time, death has become banished from our lives to form an "invisible death."

In modern times, the denial of death takes many forms. The individual will be treated as someone with an illness rather than someone dying. The person will be taken from his home and family to be in a hospital. Mourning is suppressed. The body is dressed as though still alive. There is an illusion of the continuation of this life and very little allusion to afterlife.

Mr. Aries' research stems from an analysis of the literature written at that time, from a study of wills and other documents, grave stones, and church inscriptions.

The majority of the sources are European, particularly French. He does include some analysis of American data as well, but the primary sources are French and Catholic. To the extent that we share a

common heritage with Western Europe this is quite appropriate. Some comment is made to the extent to which American and English attitudes differ. A minor annoyance is the use of occasional Latin phrases without the English translation.

This book is somewhat detailed and all-inclusive. I would especially recommend it for those physicians who regularly deal with dying patients. An interesting accompanying book might be Dr. Kubler-Ross' book "On Death And Dying."

Stanley S. Goodman, M.D.

- Dr. Goodman specializes in the treatment of cardiopulmonary diseases, practicing in Fort Lauderdale.

Know what to do and how to do it

By Toni Bagley, 92 Pages. Price \$5.00. Lakeland, 1980.

This booklet is subtitled "Parliamentary Procedure Simplified for Club Members" and is just that. It is concise, well-organized, and therefore easy to follow. However, because of its brevity, it loses its value for the chair.

Ms. Bagley bases her booklet on *Roberts' Rules of Order*. Only minor differences exist between *Roberts'* and *Sturgis Standard Code* which the FMA uses. Because some of the terminology in each book is different, some confusion may result.

In the main, this is a booklet which I could enthusiastically recommend for members who do, or plan to, participate in Parliamentary procedures.

Charles J. Kahn, M.D.

- Dr. Kahn is in the private practice of Internal Medicine. He is former Speaker and Vice Speaker, FMA House of Delegates.

An open letter to the doctors

All of us are excited by the potential of the FMA Auxiliary. As I announced at our May 8 Post Convention Board Meeting, membership is our number one priority. We now have approximately 6,000 state members out of a possible 13,000. I am appealing to every FMA member to take a long hard look at the Auxiliary and view our accomplishments. Judge for yourself if it is worth encouraging your spouse to join.

Our increasing visibility as an organization enhances our ability to promote our projects and translate our dreams into actions. At present we have five Auxilians on FMA committees and boards. Last year Auxilians raised \$80,000 for AMA-ERF; \$4,000 for the Impaired Physician Program; and \$3,389 for international health. All over the state Auxilians have been fighting substance abuse, child abuse, learning about the Impaired Physician Program; promoting programs on aging; and encouraging young people to enter health related fields. In short, Auxilians have been doing a super job promoting better health education and health care according to community needs. During March 1982, I traveled to each district in the State and was amazed by all the work that is being accomplished.

Learning Disabilities • My special health project for 1982-83 deals with learning disabilities and associated emotional problems. We plan a seminar dealing with the problem as well as providing a speakers list for the counties. We have an extremely vivacious, hard-working and capable group ready to participate actively in the legislative needs that arise. Past experience has proven that this is a valuable asset to physicians.

I am convinced that your spouses who are not Auxiliary members are not aware of the programs of our organization, or our membership would be considerably larger. I urge you to invest some time and look us over. Many of your spouses have fulltime careers; however, they could participate by joining and letting their dues work for them.

If you have further questions, please contact me or Mrs. Milton Tignor, 1982-83 membership chairman. Thank you very much.

*Mrs. Daniel B. (Gloria) Nunn
FMA-A President
Jacksonville*

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Meetings

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JULY

Curso de Medicina Ocupacional (in Spanish) July 12-16, Miami. For information: Rafael Penalver, M.D., Dept. of Office of International Medical Education, P.O. Box 016960, Miami 33101.

Ambulatory Electrocardiography: Clinical Applications, Methodology and Interpretation. July 16-18, Orlando Hyatt. For information: International Medical Education Corporation, Division of Postgraduate Education, 64 Inverness Drive E., Englewood, Colorado.

Latest Development in the Use of Calcium Channel Blocking Agents in Coronary Artery Disease, July 28, Omni International Hotel, Miami. For information: Ms. Gloria Allington, P.O. Box 016960, Miami.

Latest Developments in the Use of Calcium Channel Blocker in Coronary Artery Disease, July 29, Curtis Hixon Convention Hall, Tampa. For information: Stephen P. Glasser, M.D., University of South Florida College of Medicine, Tampa.

AUGUST

Fundamental and Clinical Aspects in Internal Medicine (A Review for the Boards in Internal Medicine) Aug. 1-14, Key Biscayne Hotel, Key Biscayne. For information: Dr. Jose Bocles, Dept. of Medicine, University of Miami, School of Medicine, P.O. Box 016960, Miami 33101.

Second Congress of Columbian Doctors in the U.S.A., Aug. 6-7, Hyatt Regency Hotel, Tampa. For information: Hugo A. Ramirez, M.D., Sam A. Nixon, M.D., (713) 792-4671.

Arrhythmias and Cardiac Ischemia: Diagnosis and Management, Aug. 13-15, Hilton Gateway, Orlando. For information: International Medical Edu-

cation Corporation, Division of Postgraduate Education, 64 Inverness Drive E., Englewood, Colorado 80112.

American Heart Association ACLS Course, Aug. 16-18, Naval Regional Medical Center, Jacksonville. For information: Frank J. Kuczler Jr., M.D., Naval Regional Medical Center, NAS Jacksonville 32214.

Comprehensive Review Course for ECFMG, FLEX, VOE (In English) Aug. 16-Nov. 24 (runs the full three months), Four Ambassador Towers Condominium, Tower 3, Suite 1950, Miami. For information: Rafael Penalver, M.D., University of Miami School of Medicine Office of International Medical Education, Miami 33101.

SEPTEMBER

Basic Mechanisms and Clinical Applications of Slow-Channel Blockers, Sept. 7, Holy Cross Hospital, Fort Lauderdale. For information: Jon R. Fichtelman, M.D., P.O. Box 23460, Fort Lauderdale 33307.

Common Knee Problems in the Professional Athlete, Sept. 8, Lakeland Yacht and Country Club, Lakeland. For information: Dr. Eugene L. Nagel, M.D., P.O. Box 927, Lakeland 33802.

Polk County Medical Association 1982 Dinner Meeting Programs, Sept. 8, Lakeland. For information: Eugene L. Nagel, M.D., P.O. Box 927, Lakeland 33802.

Tips, Tricks, Traps and Techniques, Recent Developments in Family Practice, Sept. 9-12, St. Augustine. For information: James R. Biggerstaff, M.D., 1406 Kingsley Avenue, Orange Park 32073.

Left Ventricular Dysfunction, Ventricular Ectopy and Sudden Cardiac Death, Sept. 21, Holy Cross Hospital, Fort Lauderdale. For information: Jon Fichtelman, M.D., Post Office Box 23460, Fort Lauderdale 33307.

OCTOBER

16th Family Practice Review, Oct. 4-8, Hotel Royal Plaza, Lake

Buena Vista. For information: Lamar Crevasse, M.D., Box J-233, JHMHC, Gainesville 32610.

Management of Burn Victims: Emergency, Acute and Rehabilitative Phases, Oct. 7-8, Miami. For information: Ms. Gloria Allington, (305) 547-6716.

8th Annual OB GYN Review Course, Oct. 8-16, Royal Biscayne Hotel, Key Biscayne. For information: University of Miami School of Medicine (305) 547-6944.

Violent Crime: An Epidemic, October 13, Quality Inn, Cypress Gardens, Winter Haven. For information: Eugene L. Nagel, M.D., P.O. Box 927, Lakeland.

Brief and Emergency Psychotherapy — A Seminar, Sarasota Hyatt House, Sarasota. For information: Nancy Skotchdopole, ACSW at (904) 496-3515.

89th Annual Meeting of the Association of Military Surgeons of the U.S., Oct. 17-21, Convention Center, Sheraton Twin Towers Hotel, Orlando. For information: Captain Jay R. Shapiro, USPHS (305) 496-3515.

Annual Meeting, American Pain Society, Oct. 29-31, Konover Hotel, Miami Beach. For information: Kenneth L. Casey, M.D., Neurology Service, VA Medical Center, Ann Arbor, Michigan.

Current Advances in Perinatology, Oct. 31-Nov. 6, St. Thomas, U.S. Virgin Islands. For information: P.O. Box 016960, Miami 33101.

NOVEMBER

Pacemaker Electrocardiography and Dual Chamber Pulse Generators, Nov. 3-5, Wolfson Auditorium, Mount Sinai Medical Center of Greater Miami, Miami Beach. For information: Philips Samet, M.D., (305) 674-2311.

Clinical Management of Coronary Disease and Dual-Mode Exercise Testing, Nov. 5-7, Hilton Gateway, Orlando. For information: Stephen E. Mattingly, International Medical Education Corporation, 64 Inverness Drive E. Englewood, Colorado 80112.

32nd Annual Postgraduate Seminar — Glimpses Forward — Clinical Applications of New Diagnostic Imaging and Interventional Techniques, Nov. 11-13, Mount Sinai Medical Center of Greater Miami. For information: CME Coordinator, Dept. of Continuing Medical Education, 4300 Alton Road, Miami Beach 33140.

DECEMBER

Neuro-Ophthalmology, Dec. 2-4, Miami. For information: University of Miami School of Medicine, Dept. of Ophthalmology (D880), P.O. Box 016960, Miami 33101.

ECG Interpretation and Arrhythmia Management, Dec. 3-5, Bahia Mar Hotel, Fort Lauderdale. For information: International Medical Education Corp., Division of Postgraduate Education, 64 Inverness Drive E., Englewood, Colorado 80112.

Advances in Technology for the Management of Musculoskeletal Disability, Dec. 6-8, Miami. For information: Univ. of Miami School of Medicine, Dept. of Orthopedics (D27), P.O. Box 016960, Miami 33101.

Ultrasound As Used In Modern Obstetrics and Gynecology, Dec. 8-12, Miami Beach. For information: University of Miami School of Medicine, Dept. of OB GYN, P.O. Box 016960, Miami 33101.

Brain Site Specificity of Neurotropic Drugs, Dec. 9, Dept. of Health and Rehabilitative Services, Building 1, Room 304, 1323 Winewood Blvd., Tallahassee. For information: Charlotte Maguire, Building 1, Room 304, 1323 Winewood Boulevard, Tallahassee.

Interamerican Medical Symposium — 3rd Annual Course, Dec. 12-17, Miami Beach. For information: Dept. of Medicine (R760), P.O. Box 016960, Miami 33101.

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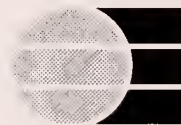
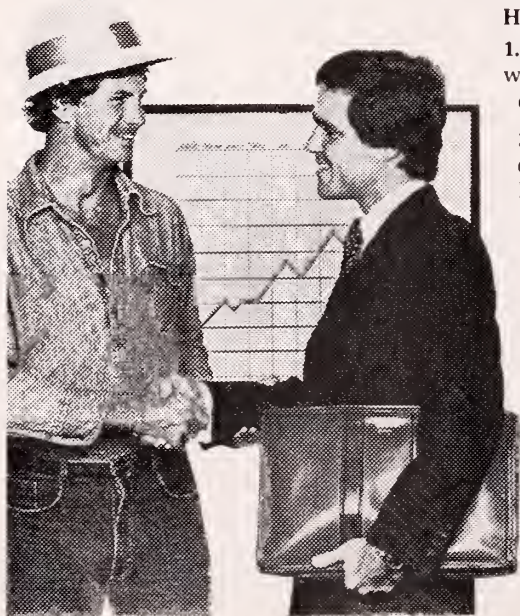
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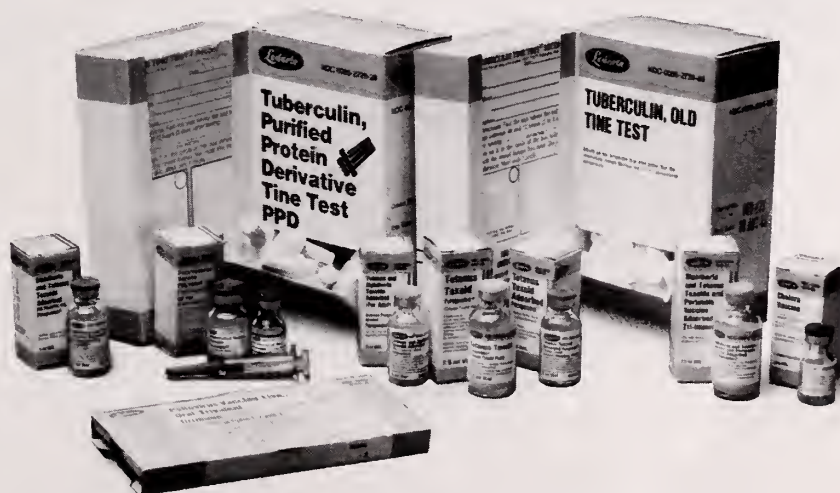
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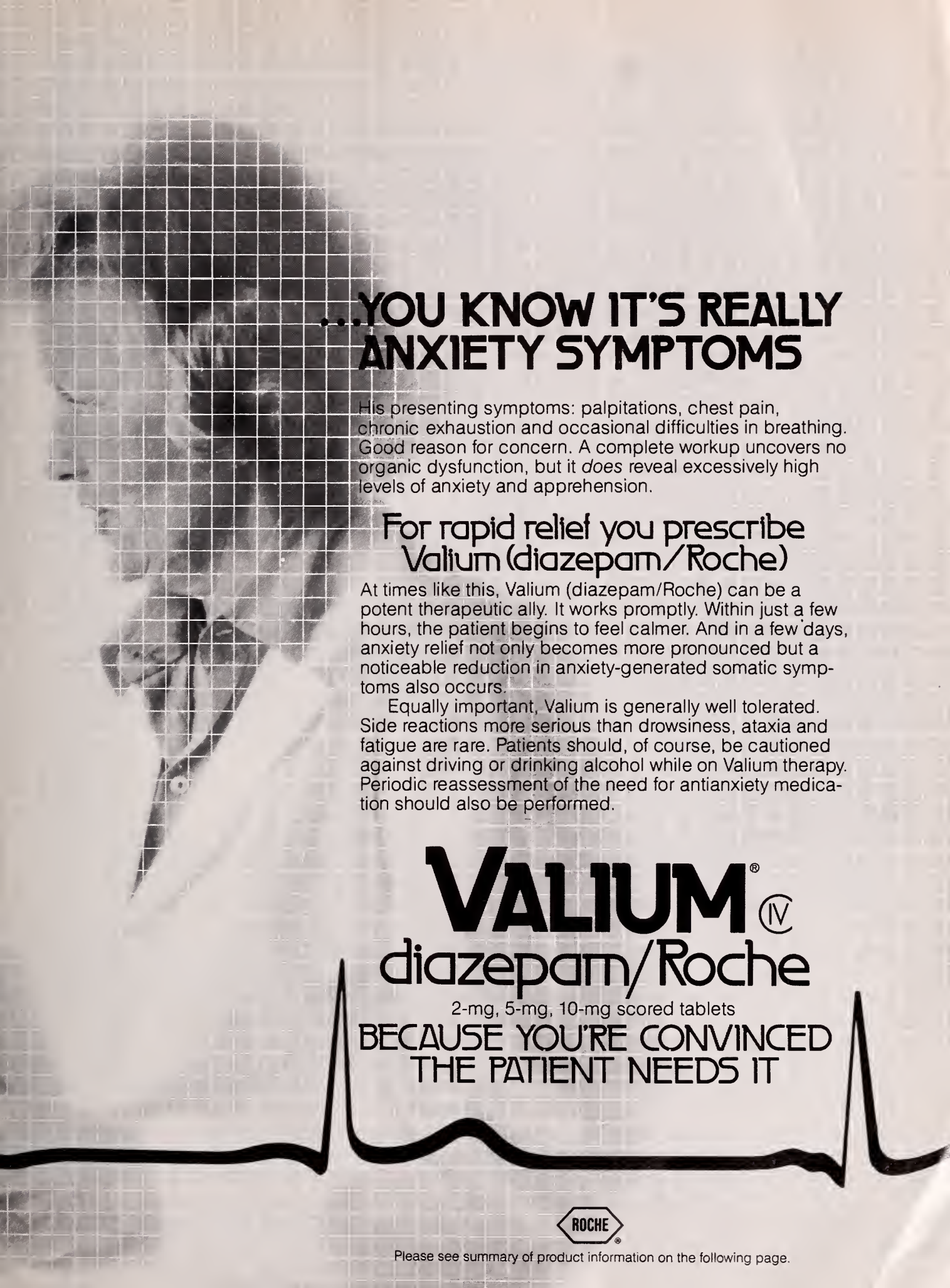


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Complete literature available on request from Professional Services Dept. PML.



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The July cover features the winner of the Editor's Award in the Sixteenth Annual FMA Auxiliary Benefit Art Show. The painting is entitled "Portrait of Dr. West Bitzer"; the artist is Jo Ellen (Mrs. David) Sneed. Both Dr. Bitzer and Mrs. Sneed are residents of Ocala.

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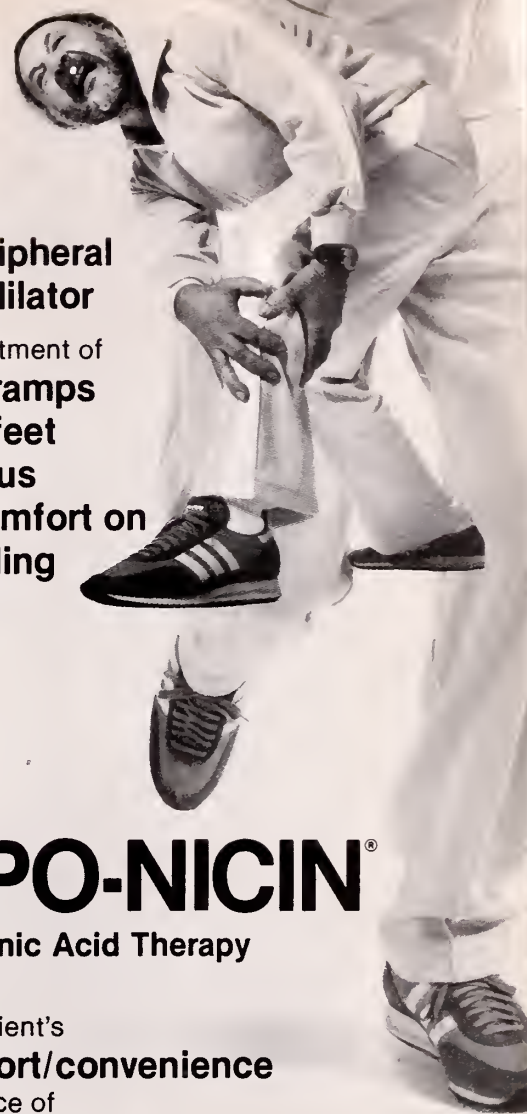
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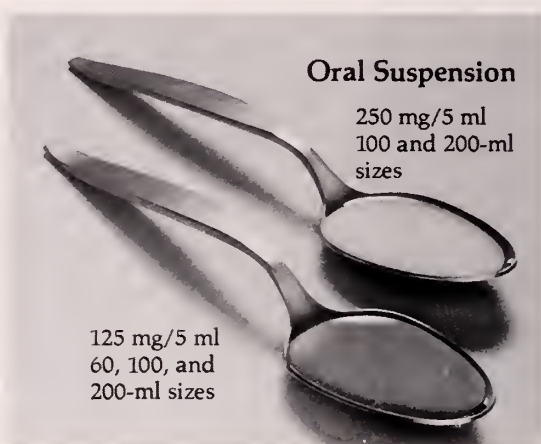
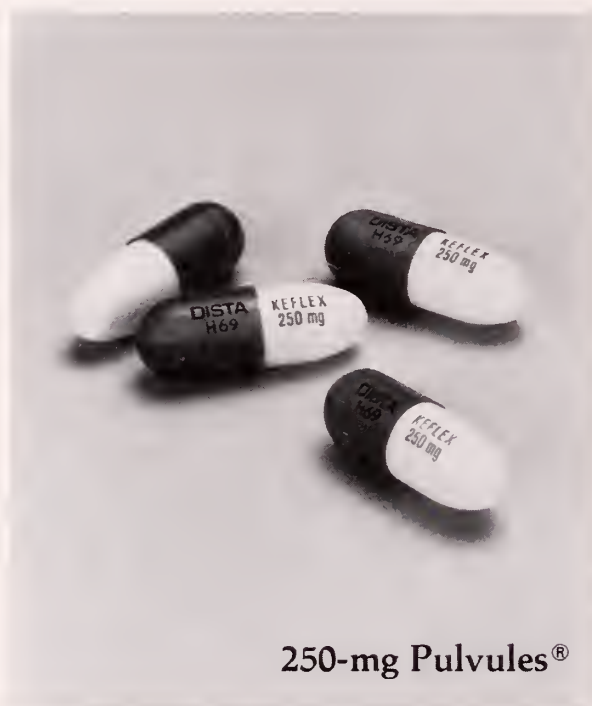
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Crisis intervention

Crisis intervention is a frequent occurrence in the practice of medicine. Although there are other jobs that have similar stressful effects upon an individual, these are for shorter periods of time in the total perspective of one's life.

In the profession of medicine there is considerable variation in the frequency and severity of these crisis-intervention experiences. High-risk surgical specialties are the ones with the more frequent incidents. However, every physician is capable of responding to such an event even if his particular area of involvement is that of a very low risk. Be that as it may, physicians are looked upon by others as the persons to whom they would turn in the event of such a crisis occurring.

Just as the general public looks to us for skills and expertise in being able to assist them, we physicians have occasion to look to them for assistance with many needs that we face. These needs usually occur in areas that relate to our community life. Problems of economic issues, employment, local government, school programs, and many other activities are usually handled by our fellow citizens outside of the medical community. Often the awareness of all that they do for us is not apparent to many physicians. Because our work is intensely oriented to our office, hospital and to hours of on-call responsibility, we tend to devote our "free hours" to those of personal interest and desire. A result of this set of circumstances finds a community of citizens highly dependent on *our* services to them individually but aware of our minimal contribution to *them* with assistance for our community needs. The image of physicians as a whole to our neighbors still is recorded in the various media as wealthy, self-seeking individuals. We know so well ourselves that this image clouds the dedicated services rendered by many of our colleagues.

Now that we are facing a crisis in the area of professional liability in Florida, we are seeing evidence in the newspapers and on television that exemplifies what I have said above. Physicians have come forth giving the public certain ultimatums regarding what



will and will not be done if we do not get financial relief. The public is seeing doctors coming out of a shell and making demands when heretofore they have shown little evidence of working with the public for common goals within the community. This produces shocking affects upon the public. Questions are raised in their minds. Letters to editors follow. Misunderstandings result. Biased statements are made. The whole scenario is so distorted that reasonable people have difficulty calming the storm.

Yes, we are in that state of affairs in Florida. May the circumstances that have prevailed be used as teaching material for the future. This is an excellent time and opportunity for us to start planning time in our schedules to devote to our fellow citizens in each community where we live. Let us show them we want to participate in local civic activities — maybe serve on the school board; attend Chamber of Commerce meetings; run for city or county commission; serve on locally appointed community boards; share our expertise with local voluntary health agencies. These are just a few ideas of many that will demonstrate our involvement for the betterment of our local community.

To do what I suggest is going to take some time — no doubt about it. It is going to alter our present routine; yet when was the last time you changed your routine? Maybe our habits need to be scrutinized and let us each find new habits that will serve us better as we in turn serve others.

I predict that if each one of us seriously gets involved more within our community we will find our neighbors and friends joining us in the future as we face other crises. Then we will have shown our commitment to them as it extends outside the medical care we give them. They will understand us more, appreciate us more, and by all means join our efforts for successful solutions to each and every crisis. They also will realize that our continued participation in civic affairs will reassure them of our commitment to work together for the betterment of our own community and state.

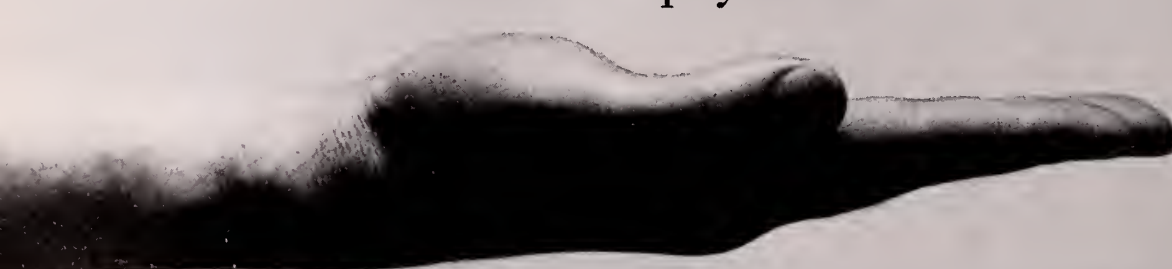
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The continuing malpractice dilemma

"I venture to guess that the inflationary rise in this year's professional liability insurance premiums has provoked reactionary comment from every member of the county medical society. Having vented my own spleen, I have subsequently contemplated the problems associated with professional liability coverage with respect to their far reaching effect on private medical practice. Personal judgment has led me to conclude that the increasing cost of this type of insurance and the lack of available coverage in some states pose a serious threat to our present free enterprise system of medical practice. Specifically, I am concerned about the definite possibility of the federal government either entering or regulating that part of the insurance industry which provides professional liability coverage. If the government does pursue this course of action, a total, nationalized health plan will most assuredly follow."¹

Although the proceeding editorial remarks were written during the 1975 "Argonaut Malpractice Crisis", the same words are, for the most part, applicable to our current PLI dilemma. Notwithstanding the efforts and accomplishments of the FMA, its members, the FMA-A, the Governor and the Florida Legislature,² we are once again facing a true malpractice crisis. In essence, the continuing increase in frequency and severity of claims with resultant steep escalation in premiums threatens to adversely affect the cost and availability of medical care as well as the financial stability of some insurance carriers.

In addressing this matter, it is important to understand that a satisfactory solution can be obtained only through state legislative action; moreover, a strong unified effort on the part of the medical profession will be necessary to achieve success. It would, therefore, behoove all of us to lend our full support to the FMA as the largest and most effective representative of organized medicine in Florida. Within the framework of the FMA, there is ample room for suggestions and legitimate differences of opinion. We simply cannot afford medical disunity.

During this period of crisis, I would hope that physicians will avoid the dangerous temptation of offering professional services to either hospitals or government in return for malpractice protection. Any action to the contrary is clearly a threat to private medical practice and could lead to our ultimate undoing.

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1. Nunn, D.B.: Professional Liability Coverage in Perspective, Jacksonville Medicine, March 1975.
2. Thames, T.B., Astler, V.B. and Coleman, F.C.: Report of the FMA Committee on Professional Liability, IFMA, November 1981.

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namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

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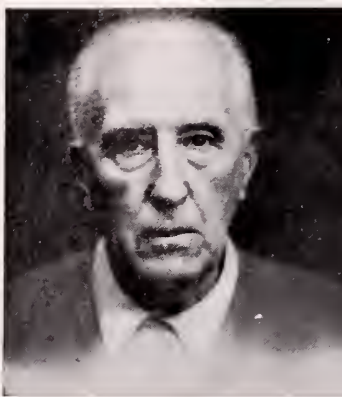
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The treatment of patients with pituitary tumors

Saul Balagura, M.D., Ph.D.

ABSTRACT: Pituitary tumors are classified as endocrinologically active or inactive. The latter may be silent or result in hypopituitarism or visual loss. The former most frequently hypersecrete prolactin, growth hormone, adrenocorticotrophic hormone and may also result in hypopituitarism. Current treatment necessitates a multidisciplinary approach. Bromocriptine is a palliative but very useful drug in the present treatment of prolactinomas. Definite surgical treatment is now accomplished safely via the transsphenoidal route; the subfrontal approach is used in very few instances. With the advancement of the CT scan and radioimmunoassay techniques, these patients can be followed postoperatively and can be offered further treatment with surgery, bromocriptine or radiation if residual or recurrent tumor is documented.

Pathological processes related to the pituitary gland and hypothalamus require a multidisciplinary approach for their understanding and management. Despite current progress in endocrinology, gynecology, neuroradiology and neurosurgery, we still lack a clear picture of the etiology, pathophysiology and natural history of pituitary tumors.

It is possible to induce pituitary tumors in experimental animals by specific manipulations. For example, in the rat chronic administration of diethylstilbestrol (DES) can induce pituitary enlargement and formation of pituitary tumors.¹ In the author's laboratory, it was possible to reliably produce pituitary tumors in ACI rats two months after the subcutaneous implantation of a 10 mg. pellet of DES. The tumors became larger and invasive, spreading to the temporal fossa and invading the cavernous sinus. Clearly, the interaction of DES and time was important for the transformation of normal pituitary glands into hyperplastic, then adenomatous, and finally invasive giant tumors.

In human beings with pituitary tumors no clear-cut etiological factor has been demonstrated. One cannot ascribe the induction of pituitary tumor to adrenalectomy, even in cases of Nelson's syndrome, for it is possible that such tumors existed prior to adrenalectomy. No clear-cut causal relationship has been found between birth control pills and pituitary tumors.

The Author

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Classification • Pituitary tumors are classified according to their biological and endocrinological profile. *Endocrinologically*, tumors can be active or inactive. Active tumors may secrete prolactin (PRL), growth hormone (GH), adrenocorticotrophic

hormone (ACTH) or, rarely, thyroid stimulating hormone. They also may produce endocrinological changes due to pituitary and hypothalamic hypofunction, and these are variable depending on whether they involve one or more hormonal systems. *Biologically*, tumors may vary in size as well as in speed of growth. They may be invasive or non-invasive. At the present time, it is easier to determine the endocrinologic classification of a tumor than it is its biologic nature; the biologic course, in fact, is unpredictable. Some patients may present with a small pituitary adenoma that will remain the same size for many years. Other patients may harbor tumors that change rapidly, demonstrating a sudden alteration in the biological nature of the tumor. Still others present with the sudden appearance of signs and symptoms of a massive, invasive tumor.

The prevalence of clinically significant pituitary tumors is not well known. Autopsy studies have shown a significant prevalence even in patients who apparently had not complained of hormonal or visual disturbances referable to pituitary function.^{4,5} The apparent recent increased incidence of clinically significant pituitary tumors probably reflects the better tools with which clinicians are equipped, as well as a more open society where complaints of sterility, amenorrhea and impotence are discussed freely between patient and doctor.

Clinical Presentation • Clinical signs and symptoms may result from either the biological or endocrinological behavior of the tumor. Patients with nonsecreting pituitary adenomas may present with symptoms referable to the visual apparatus resulting from compression of the optic nerves or chiasma as the tumor expands into the suprasellar area. If the tumor invades the cavernous sinus, the symptomatology is referable to either obstruction of the cavernous sinus or to direct impingement upon one or more nerves within the sinus. When suprasellar enlargement is such that the tumor reaches the foramen of Monro, hydrocephalus may develop. Many other variations of the clinical presentation exist, depending on the expansion of the tumor. In addition to the clinical picture resulting from the effects of the pituitary tumor acting as a mass upon other neural structures, the tumor itself may destroy pituitary function. These patients may present to the clinician with symptoms and signs referable to specific hormonal hypofunctions. These may vary from hypogonadism to panhypopituitarism, and the time course may be slow or sudden as in pituitary apoplexy.

Endocrinologically active tumors can be readily detected with specific radioimmunoassays; however, before a blood sample is taken, the clinician must suspect a pituitary disturbance. Prolactin and GH levels should be taken routinely in any patient presenting with amenorrhea or galactorrhea, as well as

in men complaining of impotence. ACTH or cortisol determination is imperative in cases where Cushing's disease or Cushing's syndrome is suspected. Furthermore, there is a battery of inaccurate but sometimes helpful stimulatory and inhibitory tests to further tease out the endocrinological behavior of the hypothalamic-pituitary system. A keen clinical eye with the right index of suspicion remains the most important device available for the detection of acromegaly. Very frequently, the family and close friends of the acromegalic patient may not detect any changes in the patient, or may assume that the changes in the face and limbs are due to normal aging. Once suspected, a simple GH test may corroborate the diagnosis. If GH is within normal range, but the physician still suspects acromegaly, 24-hour growth hormone monitoring should be undertaken.

Treatment • Of the clinically symptomatic pituitary tumors, approximately two-thirds are endocrinologically active. Our interest as physicians must be directed at correcting mass effects and adrenohypophyseal hypersecretion of specific hormones that may be causing an untoward reaction. It is important to consider carefully the possible dangers of following either a conservative or a more aggressive form of therapy. Physicians have often paid more attention to the risk of active therapy than to those complications resulting from conservative treatment, often taking the stand that the latter is the natural course of events.

Clinical wisdom dictates that the right time to intervene in the case of a mini-adenoma is just before it becomes invasive and out of control. Pituitary hormone blood levels are useful in anticipating this point in the biologic course of pituitary adenomas. In the study of 300 patients with prolactinoma, Aubourg et al⁶ demonstrated that the majority of invasive tumors were found in patients having preoperative PRL serum levels above 200 ng/ml. We have also demonstrated that a prolactin level above 150 ng/ml. is indisputable evidence of a pituitary tumor.⁷ Lower levels, especially below 100 ng/ml., may be seen in entities other than pituitary tumors. Thus, a PRL level in the narrow range between 150-200 ng/ml. indicates the presence of a pituitary tumor with a high potential for cure by selective transsphenoidal adenomectomy. In a study of 150 cases of acromegals⁸, serum GH level was also found to be a useful marker of tumor invasiveness. Patients having preoperative GH values below 70 ng/ml. had a higher cure rate than those with GH levels above 70 ng/ml. Hence, the clinician must not only look for signs of physical enlargement (tomography, CT scanning, visual field defects), but also for endocrinological signs that indicate an increased aggressiveness of the tumor without a concurrent increase in tumor size.⁹

Prolactin - Secreting Tumors • Three modes of management are currently in practice one of which is

conservative observation, submitting the patient to semi-annual checkups. Usually these patients are young women that make use of their prolactinoma as a contraceptive device. More recently, *Bromocriptine* (2-bromo-a-ergocryptine) has been shown to have a marked inhibitory effect on prolactin secretion; there is some preliminary evidence to indicate that, in certain cases at least, it may also have an effect on the biological nature of the tumor by decreasing size or suppressing growth¹⁰⁻¹³; however, there are also reports indicating that the effect may be temporary or even ineffective.¹⁴ *Bromocriptine*, which is a dopamine agonist, acts both at the hypothalamic and pituitary systems,¹⁵ as well as directly on tumor cells.¹⁶ It is given in a dose of 5-10 mg. per day, starting with an initial dose of 1.25-2.5 mg. per day and progressively increasing the amount over a two to three week period. This drug, however, has not yet been approved by the FDA as a mode of therapy for pituitary tumors.¹⁷

The surgery for prolactin-secreting tumors is now mostly directed at the removal of the tumor preserving pituitary function (selective adenomectomy). The least traumatic surgical route to the pituitary is the transsphenoidal approach to the sella.¹⁸ The mortality and morbidity of this procedure in capable hands is now quite low, varying between one and two percent.^{6,19-22}

Growth Hormone Secreting Tumors • Both patients harboring pituitary hypersecreting growth hormone tumors and acromegalic patients should be treated as early as possible before their facies are changed and deformed in an irreversible manner by the action of the hormone. The control of growth hormone secreting tumors with drugs has not been as successful as with prolactin. Several series have demonstrated that *Bromocriptine* has a partial but unsatisfactory effect on the control of excess GH secretion by pituitary tumors.²³⁻²⁵ Radiation therapy is considered inadequate as the primary line of therapy because of the morbidity and the fact that its tumoricidal effects take a long time before decreasing GH to a normal level.²⁶ Thus, the main treatment of acromegaly at this point is the direct surgical attack of the tumor by selective adenomectomy.^{8,27-28}

ACTH Secreting Tumors • Rapid normalization of ACTH levels is the primary aim of therapy in Cushing's disease. The presence of pituitary ACTH secreting tumors in as many as 90 percent of patients with Cushing's disease has made the direct surgical attack on the pituitary adenoma the preferred mode of therapy.²⁹⁻³² In small clinical series,³³ cyproheptadine, a drug with multiple effects on serotonergic, dopaminergic, cholinergic and histaminergic systems, has been found to have a positive effect on the control of cortisol; however, the therapeutic effect occurs several months after the initiation of treatment

with the drug and no tumorlytic effect has been demonstrated.

Nonsecreting Pituitary Tumors • Since these tumors do not secrete hormones, treatment is directed to the prevention of their extension and invasion to other brain areas such as the visual optic pathways and cavernous sinus. The development of high definition CT scanners facilitates the radiological follow-up of these patients.³⁴ Although both subfrontal craniotomy³⁵⁻³⁶ and transsphenoidal approaches³⁷ are used, the choice of technique is determined by the extension and shape of the tumor, as well as by the surgeon's preference.

Pituitary Apoplexy • Necrosis and hemorrhage into a pituitary tumor may result in resolution of the disease or may produce serious and even fatal consequences.³⁸⁻⁴¹ The treatment should be directed at both the prompt replacement of critical hormones and surgical decompression of the pituitary. The transsphenoidal approach is now preferred.

Radiotherapy plays an important role in the treatment of pituitary tumors.⁴²⁻⁴⁶ It is best used in the supplementary treatment of hormonally active tumors following incomplete surgical removal (persistent postoperative endocrine hypersecretion). Radiotherapy should also be used in nonsecreting tumors in which invasion to parasellar structures did not permit complete surgical excision. Incompletely removed nonsecreting tumors can be followed with CT scanners. After demonstrating that the tumor-mass is growing again, the patient may be submitted either to re-operation or to radiation therapy. There is no clear-cut agreement as to when therapy should be given, but it is known that the best time to give radiation therapy is when the tumor mass is at its minimum. Finally, there is an increasing number of clinical papers reporting complications secondary to radiation therapy.^{26,47-54} In short, this mode of treatment is not as innocuous as previously thought.

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Tracheobronchial laser surgery

George L. Kullman, M.D.

ABSTRACT: The recent advance of laser surgery to include lesions of the tracheobronchial tree has opened a modality of treatment to otherwise nonresectable lesions in the area of the trachea and main stem bronchi. The use of this tool has allowed removal of both benign and malignant lesions of the trachea and bronchi transorally.

The purpose of this paper is to report my initial twelve month experience with the Cavitron CO₂ laser and to offer my impressions regarding this form of treatment.

Thirteen endoscopic laser removal procedures were carried out in six patients over the past twelve months. The 40 x 8 mm Wolff bronchoscopic attachment of the Cavitron CO₂ laser was used in all instances. All but one of the six patients were suffering from carcinoma of the trachea and/or carina area. General anesthesia was administered through the side arm of the bronchoscope in the usual fashion with a cuff placed around the distal end of the instrument. The cuff used was a "Foregger Soft Cuff" of 8 mm size. This allowed good air exchange, maintained mobility of the bronchoscope and facilitated removal of smoke produced by the procedure. It was necessary to use the laser at full 30 watt capacity and the usual time requirement for the removal of an obstructing lesion was 60 to 90 minutes.

Illustrative Cases • Case I — A 74 year old male suffering from poorly differentiated squamous cell carcinoma of the distal trachea and right main stem bronchus required two treatments five weeks apart, both at a time when he developed rather marked obstructive symptoms. Each time, laser treatments resulted in a good airway and the patient was discharged from the hospital within one to two days following surgery. Unfortunately, the patient developed generalized carcinomatosis and died four and a half months after the laser surgery. However, the laser treatment successfully prevented recurrent respiratory obstruction.

Case II — A 52 year old white male with well differentiated mucus producing adenocarcinoma of the distal trachea and right main stem bronchus had three separate laser treatments on July 17, September 10, and December 8, 1980. The patient died December 20, 1980 because of a sudden exsanguinating pulmonary hemorrhage. Each transbronchoscopic treatment resulted in two to three months remission. No bleeding problem was encountered during any of the three surgical procedures.

Case III — A 72 year old male was seen because of a history of benign tracheal polypoidosis which began in 1973. An 80-85 per-

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tracheal obstruction was located at the junction of the middle and distal thirds. Laser removal was accomplished to within five or ten percent residual visible tumor.

Pathologic examination showed this to be a well differentiated verrucous squamous cell carcinoma. Despite this finding, the patient has remained asymptomatic for the past six months. Hence additional treatment has not been afforded.

Case IV — A 63 year old white male was seen because of an obstruction of the distal trachea produced by a metastatic adenocarcinoma clear cell from the kidney. This patient underwent two treatments — October 17 and October 21, 1980. Severe bleeding was encountered at the time of surgery on both occasions, limiting the efficiency of the procedure. After both procedures, the patient required blood transfusions, and it was judged that further attempts were contraindicated. The vascularity of the clear cell carcinoma was a severe limiting factor in this instance.

Case V — A 52 year old black male with a history of poorly differentiated squamous cell carcinoma, large cell variant, of the distal trachea and both main stem bronchi had four transbronchial laser treatments on July 3 and 24, September 18 and 23, 1980. Of note is the fact that on both admissions in July and September, he required two treatments each.

The initial treatment on each admission had to be terminated prior to satisfactory removal of the tumor because of excessive bleeding. The patient died in late November, due to respiratory arrest, without any evidence of hemoptysis in the interval.

Case VI — A 75 year old white male was seen because of a history of chondroma of the proximal trachea. One year prior to referral, the patient had an anterior tracheotomy with surgical removal of the tumor. The tumor recurred within a twelve month period of time, causing 80 to 85 percent obstruction of the proximal trachea immediately distal to the larynx. This tumor was removed with one laser treatment, and the patient was able to leave the hospital the following day.

Discussion • Until recently, radiation therapy and direct forcep removal were the only forms of treatment available for distal tracheobronchial neoplasms that impinge on the airway and cause atelectasis, pneumonia, dyspnea and death¹.

With the advent of the surgical CO₂ laser coupled to a rigid bronchoscope (Figures 1 and 2), it is now possible to remove tumors of the tracheobronchial tree, which were heretofore unresectable. "Laser" is an acronym for Light Amplification by Stimulated Emission of Radiation. The carbon dioxide laser is similar to a neon tube, as the carbon dioxide gas is activated by a high voltage electric current. The photons produced results in a coherent beam of light in the 10.6 micron range, which is close to the infrared spectrum with a large amount of thermal energy. The beam is manipulated through a series of mirrors and prisms, but cannot be led through a fiberoptic bundle.

The carbon dioxide laser functions as a thermal beam which is almost completely absorbed by the tissue and raises both the intracellular and extracellular water temperature almost instantly to 100°C. This results in instantaneous destruction of cellular elements. In addition, a physiochemical reaction occurs with denaturation of proteins, resulting in a marked hemostatic effect on lymphatic and vascular channels. Tissue destruction is well-defined and

there is rapid healing by the action of adjacent, uninjured tissues.



Figure 1.

For endobronchial surgery, the beam of light is led directly through a pistol-grip attachment into a rigid bronchoscope (Figure 1). This bronchoscope is modified with a "Foregger endotracheal soft cuff", as illustrated, to allow a closed anesthetic system. The anesthetic gases are delivered through the bronchoscope and thus eliminate the need for endotracheal tubes. Nonexplosive anesthesia and low concentrations of O₂ are used to prevent any possibility of ignition of gases.

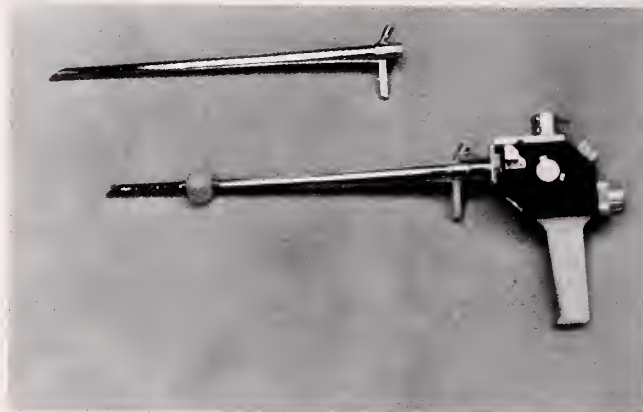


Figure 2.

At the present time, the surgical laser is capable of producing 30 watts of power in a continuous mode and at this maximum setting, approximately one hour of surgery time is required for an average size obstructing lesion. In treating obstructing malignant lesions, the procedure should be considered palliative, since it is generally not possible to remove the entire malignancy. The limiting factors in the procedure are location of the tumor and the ability to reach the lesion with the rigid bronchoscope. In our experience, it was found that even with extensive removal by the

laser, there was little morbidity and to date there has been no operative mortality. The major complication is intraoperative bleeding if a blood vessel of more than 0.5 mm is encountered. In the series presented, the metastatic clear cell carcinoma from the kidney was the only case in which there was significant bleeding. Despite this problem, the patient did well postoperatively and received excellent palliation.

As has been described previously^{2,3}, it has been shown that laser treatment produces a very localized effect on the tissues with very little reaction of the surrounding structures. Generally, with smaller blood vessels, the laser has been found to be quite hemostatic and with most tumors bleeding is not a problem. One of the most striking features of this

treatment is the fact that after adequate removal of the tumor, most patients are able to leave the hospital within 24 to 48 hours, keeping hospital costs at a low level. Furthermore, the procedure can be utilized repeatedly, if necessary. It would appear, therefore, that the treatment of obstructive tracheobronchial lesions with the CO₂ laser is a superior palliative measure in otherwise untreatable situations with almost absent morbidity and mortality.

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Metastatic potential of biologic variants of skin squamous cell carcinoma

Franklin H. Cox, M.D. and Ferdinand F. Becker, M.D.

ABSTRACT: *The biologic behavior of squamous cell carcinoma of skin is reviewed. It is commonly accepted by many authors that infiltrating squamous cell carcinoma associated with solar keratosis rarely metastasizes. However, the adenoid squamous variant, an elevated nodular lesion of the head and neck originating in the outer pilar sheath, may show aggressive behavior. In our series of six patients with extensive adenoid squamous carcinoma, four had lymph node metastases and all six involved the parotid gland. Acantholytic solar keratosis was a frequent precursor of this neoplasm. Another potentially dangerous infiltrating squamous cell carcinoma of skin is the de novo squamous cell carcinoma with an incidence of metastases in 8-10% of patients. This diagnosis is substantiated by the presence of normal skin margins revealing no evidence of actinic damage and dyskeratosis. Finally, the infiltrating carcinoma associated with Bowen's disease will metastasize in approximately 10-35% of the patients. Therefore, it is important for pathologists to accurately differentiate the different biologic variants of infiltrating skin squamous cell carcinoma. If sections of adjacent skin margin demonstrate the changes of actinic keratosis in the absence of adenoid squamous carcinoma and Bowen's disease, a favorable outcome can be predicted, requiring minimal additional surgical excision.*

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Most physicians think of squamous cell carcinoma of skin as a single entity with potential metastatic behavior, in contrast to basal cell carcinoma which never metastasizes. In the past decade many authors and dermatopathologists have stated that squamous cell carcinoma associated with actinic keratosis rarely will metastasize. An attempt will be made in this paper to differentiate biologic variants of squamous carcinoma involving skin in terms of their malignant potential. Basal cell carcinoma will not be further discussed except to say that a recent article from the Armed Forces Institute of Pathology summarizes 119 cases of metastatic basal cell carcinoma, the most common sites of metastases being bone and lung. Seventy-five percent of the cases were classified as metatypical (baso-squamous) basal cell carcinoma.¹

It became apparent to one of the authors whose practice is confined to Head, Neck and Facial Surgery, that several patients with squamous cell carcinoma of skin of the head and neck region had extensive disease with a high incidence of parotid gland and lymph node metastases. Accordingly, the records of these patients spanning the years from 1974-1980 were reviewed.

Patient Survey ● A report on nine patients, most of whom are elderly and male, is summarized in Table 1. In six of the nine patients the original lesion is classified as adenoid squamous cell carcinoma, also called acantholytic or pseudoglandular carcinoma (Figure 1). This type of carcinoma does have a preceding actinic keratosis which is often acantholytic in type. Four of six patients with adenoid squamous cell carcinoma did show marginal acantholytic actinic

Table 1. — Squamous Cell Carcinoma (SCC) with Local Extension and/or Metastases.

Age/ Sex	Type	Parotid Involvement	Lymph Node Metastases
82 M	Adenoid SCC	Yes	Yes
59 M	Adenoid SCC	Yes	Yes
70 M	Adenoid SCC	Yes	Yes
52 M	Adenoid SCC	Yes	Yes
98 M	Adenoid SCC	Yes	No
80 F	Adenoid SCC	Yes	No
79 M	De Novo SCC	No	No
80 M	Anaplastic SCC (Post Radiation)	Not removed	Yes
85 F	Infiltrating SCC (? origin epidermal cyst)	Yes	Yes

keratosis. Clinically, the lesion appears as an elevated nodular tumor and may resemble a keratoacanthoma (Figure 2). Adenoid squamous cell carcinoma is thought to originate from the outer root sheath of the hair follicle, and over 90% involve the head and neck region.²

One patient's lesion was classified as "de novo" squamous cell carcinoma based on normal skin margins. Another patient had a history of previous radiation therapy to the involved area, and the final patient had an apparent origin from a subepidermal cyst. In none of the nine patients was metastatic squamous cell carcinoma associated with actinic keratosis other than the adenoid squamous type.

Moreover, all six patients with adenoid squamous cell carcinoma had involvement of the parotid gland, with lymph node metastases in four. This high incidence of parotid gland involvement in metastatic squamous cell carcinoma from skin of the head and neck makes it imperative to include parotidectomy in the surgical treatment of neck metastases.

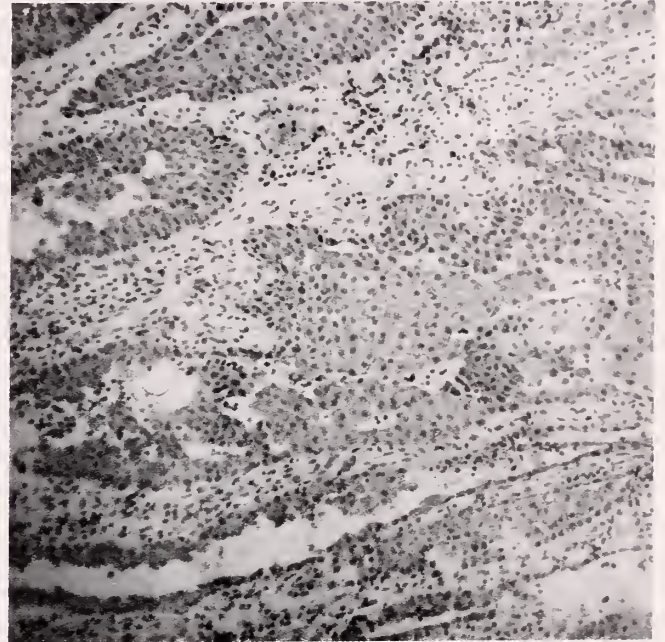
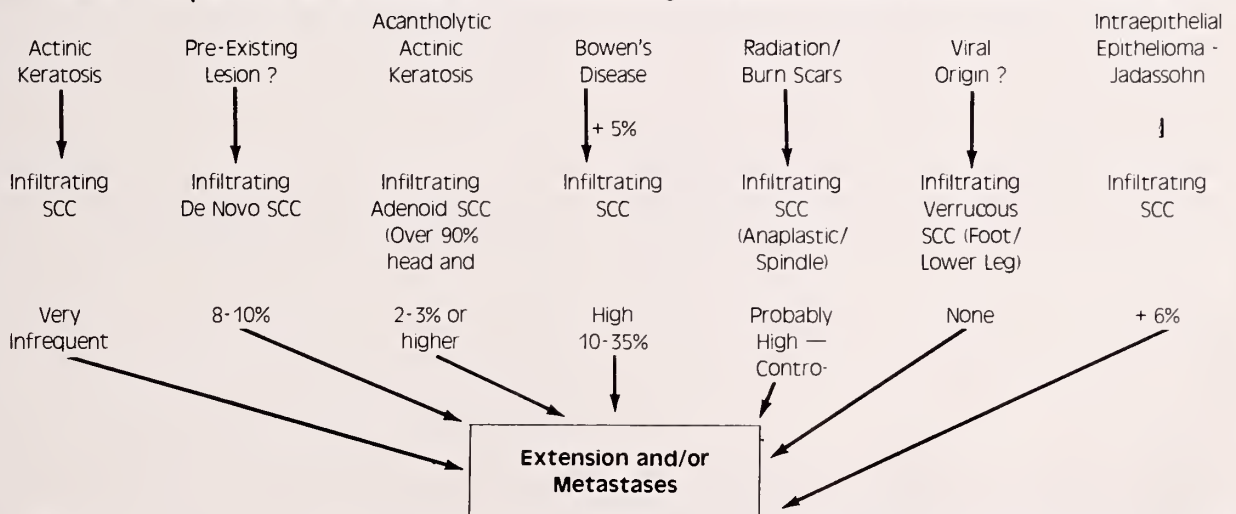


Fig. 1. — Photomicrograph of adenoid squamous cell carcinoma showing pseudoglandular formation and acantholysis.

Biologic Variants • Table 2 summarizes the biologic variants of skin squamous cell carcinoma and their approximate metastatic potential. The most common squamous cell carcinoma of skin is still infiltrating carcinoma associated with actinic keratosis; and if we can exclude adenoid squamous cell carcinoma, metastases are very infrequent.³

Table 2. — Squamous Cell Carcinoma (SCC) of Skin Showing Pre-Existent Lesions and Metastatic Potential



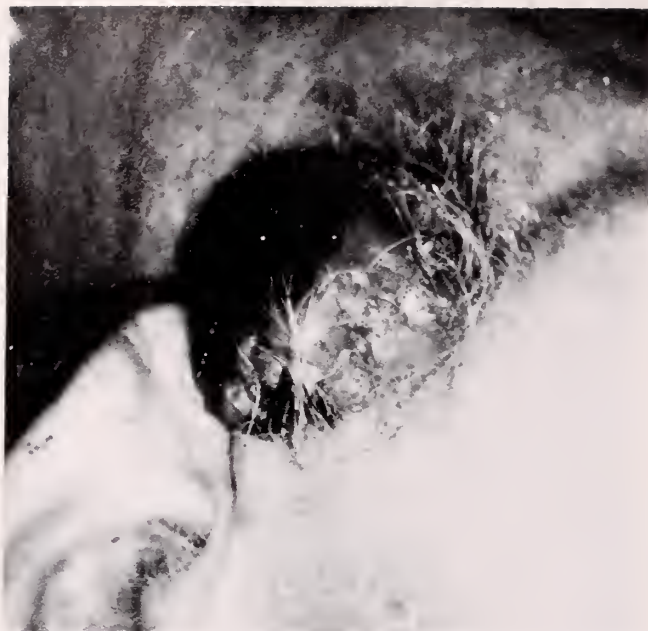


Fig. 2. — Clinical photograph of adenoid squamous cell carcinoma showing the typical elevated nodular tumor located at the angle of jaw.

The entity *de novo* squamous cell carcinoma occurs on both sun-exposed and unexposed skin and is identified by normal epidermal margins. It is, therefore, important to include adjacent marginal skin in the biopsy. The incidence of metastases is somewhere around eight percent.⁴

Adenoid squamous cell carcinoma is probably more common than realized; and since it involves the head and neck region and is associated with actinic damage, the incidence would be higher in the sunbelt region. Moreover, metastases may be higher than the two to three percent reported in the literature.

Bowen's disease also occurs in the sun-exposed and unexposed skin. It has a characteristic erythematous scaly plaque and microscopically must be differentiated from Bowenoid actinic keratosis. The incidence of infiltrating carcinoma is low, but once this occurs the incidence of metastases is high.³

The anaplastic or spindle cell squamous cell carcinoma seen in radiation therapy and burn scars has been reported to have a high incidence of metastases by some authors; others claim the opposite.⁴

Verrucous carcinoma occurs in skin, oral/upper respiratory region, and the genital areas. Involvement of skin is seen almost exclusively in the foot and

lower leg. While recurrence is common after local excision, metastases do not occur.⁵

Intraepithelial epithelioma of Jadassohn involves skin most commonly in the lower half of the body and probably originates from the intraepidermal sweat duct. The incidence of infiltrating squamous cell carcinoma and subsequent metastases is approximately eight and six percent respectively.^{3,6}

Summary • The biologic behavior of squamous cell carcinoma of skin is reviewed. It is commonly accepted by many authors that infiltrating squamous cell carcinoma associated with actinic keratosis rarely metastasizes. However, the adenoid squamous variant, an elevated nodular lesion of the head and neck originating in the outer pilar sheath, may show aggressive behavior. In our series of six patients with extensive adenoid squamous carcinoma, four had lymph node metastases and all six involved the parotid gland. Acantholytic actinic keratosis is a frequent precursor of this neoplasm.

Another potentially dangerous infiltrating squamous cell carcinoma of skin is the *de novo* squamous cell carcinoma with an incidence of metastases in approximately eight percent of patients. This diagnosis is substantiated by the presence of normal skin margins revealing no evidence of actinic damage and dysplasia. Other biologic variants of skin squamous cell carcinoma are briefly summarized.

Pathologists should make every effort to differentiate these biologic types and surgeons should plan their therapy accordingly. If sections of adjacent skin margin demonstrate the changes of actinic keratosis with the absence of adenoid squamous carcinoma a favorable outcome can be predicted, requiring minimal — but complete — surgical excision.

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Measles elimination in Florida

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ABSTRACT: A national effort to eliminate indigenous measles transmission by October 1, 1982, was launched in 1978 through the Centers for Disease Control (CDC). Measles morbidity (cases per 100,000 population) has dramatically declined from 26.5 in 1977 to 1.3 in 1981 — a 95 percent decrease. The elimination effort is based on maintaining high immunization levels, case detection, and outbreak control. Florida's new immunization law, passed in 1981, requires that for school attendance all students in public and non-public schools, grades kindergarten through 12th grade, be immunized against diphtheria, tetanus, pertussis, polio, measles, mumps and rubella. Students must have documentation of these immunizations on file at school by August 1, 1982, or they will be temporarily excluded from school. Physicians can assist the statewide effort in measles elimination by providing routine immunization services, recalling for re-immunization children who received measles immunization before their first birthday, reporting promptly suspect cases to the county public health department, and obtaining serologic confirmation of suspect measles cases.

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In 1978, the Department of Health and Human Services through the Centers for Disease Control (CDC) launched an initiative to eliminate indigenous measles transmission by October 1, 1982. So far, this nationwide effort has been extraordinarily effective in reducing measles morbidity to the lowest level ever (from 26.5 cases per 100,000 total population in 1977 to 1.3 cases in 1981 — a 95 percent decrease). The elimination initiative is based on maintaining high routine immunization levels, enactment and enforcement of comprehensive kindergarten through 12th grade (K-12) immunization laws with exclusionary provisions, and surveillance and control of outbreaks.¹ Data show that states which enforce school immunization laws rigorously including temporary exclusion when a measles case occurs, have drastically reduced indigenous measles transmission and, in some instances, have become measles free.^{2,3}

Measles morbidity in Florida has been declining (Fig. 1) along with the national trend; however, during the last three years (1979-1981) Florida has been one of the top 10 states for measles cases reported. In 1978, the downward trend that had begun in the late 1960's and early 1970's was temporarily reversed, probably due to reductions in federal funding of the state immunization projects and the occurrence of measles outbreaks among high school students. In 1980-81 measles cases have occurred less frequently in high school age children but continue to occur in pre-schoolers. The age specific incidence rates for 1981 and the mean annual rates for the four year period 1978-81 are shown in Table 1.

Immunization law for Florida • To combat the problem of measles virus transmission in schools

(with concomitant spill over into child care centers and the community) the Florida Legislature passed in 1981 a comprehensive K-12 school immunization law (Florida Statute 232.032) which includes a temporary exclusion provision. For attendance in Florida's public and non-public school, grades K-12, the law requires that students be immunized appropriately (or exempt for medical/religious reasons) against diphtheria, tetanus, pertussis, polio, measles, mumps and rubella. Students not having a Florida immunization certificate (or exemption certificate) on file at their school after August 1, 1982 are to be excluded temporarily from school by school officials until they comply.

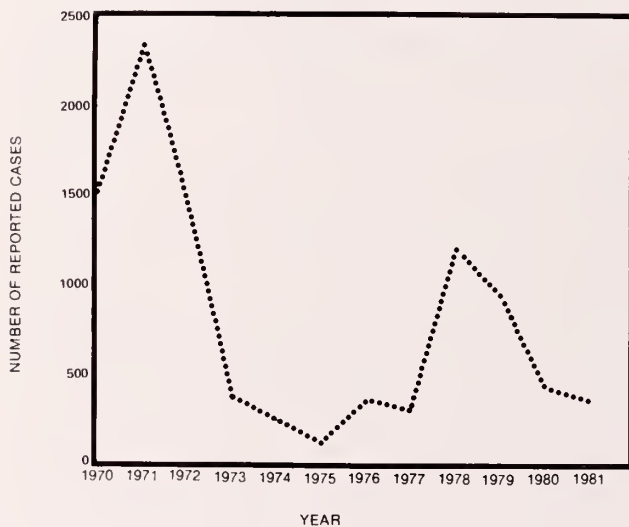


Figure 1. — Reported Measles Cases, Florida, 1970-81.

During the current school year, county public health department and school officials will be making an effort to identify students not in compliance with immunization requirements. All students who are updating their immunization records should have noted on their record the date (month, day and year) of measles immunization showing that the measles vaccine was given on or after January 1, 1968 and on or after their first birthday. (We realize that the current recommendation is to give measles immunization at 15 months of age; however, for public health purposes, receiving the measles immunization on or after the first birthday provides adequate immunity to prevent significant measles transmission in school.) Measles vaccine efficacy in children who were immunized before their first birthday is considerably lower than that for children immunized on or after their first birthday.^{4 5}

The new law also provides the county public health department director with the authority to declare a measles school exclusion emergency if a measles case occurs in a student attending public or non-public school. In such an emergency, students

will be given two to five days to provide documentation that they have received measles vaccine on or after January 1, 1968 and on or after their first birthday. Students who cannot provide such documentation will have to receive measles immunization before they return to school. A history of past measles disease is acceptable in lieu of immunization only if a physician certifies on his/her stationery that the child has had an illness with a generalized rash that lasted three or more days, a fever of 101°F or greater, a cough, and conjunctivitis and, in his/her opinion had the 10-day measles (rubeola). Notes on prescription pads, statements without symptoms, etc. are not acceptable. Children who received normal human immune globulin (IG) as a preventive measure in lieu of immunization after exposure to a case will be allowed to attend school for a half-life of the product (30 days). If the exclusion program is still in effect 30 days after the IG was given, IG will have to be repeated to allow continued attendance. Children with permanent medical or religious exemptions will be kept out of school for their own protection and the protection of others until the measles emergency is declared over. In general, the emergency exclusion policy will remain in effect until 21 days after the onset of rash in the last case.

Potential problem areas • An area of particular concern in Florida is the influx of children visiting from Latin America each summer. Many of these children visit tourist attractions and remain in Florida in summer camps. Imported measles cases were responsible for two outbreaks in summer camps in 1981 (two and three cases, respectively) and the index case for the large Pasco/Pinellas County outbreak that began in January 1981 (149 cases) was a visiting soccer player from Mexico. Outbreaks traced to imported cases have occurred in many other states.⁶

Day care centers can also provide a fertile ground for measles virus transmission. In November 1981, a day care center outbreak accounted for 18 cases in attendees, three community associated cases, and three cases associated with a day care center hospitalized case.

The typical symptoms and course of illness of a measles case are usually easily identifiable and are described in many textbooks. At minimum, a person with measles should have an illness with a generalized rash of three or more days duration, a fever of 101°F or greater, and respiratory symptoms (cough, conjunctivitis, or runny nose). In some instances, other rash illnesses will meet these minimum criteria, but on clinical grounds would not be called measles. Drug rash, particularly following antibiotics given to a child with a febrile respiratory illness, is often one of the more difficult syndromes to distinguish from measles.

Besides typical measles there are two other distinct syndromes that occur with a measles virus infection. One has been called "modified" or mild measles. This entity, about which there is little in the medical literature, occasionally occurs in a child who has partial immunity to measles.⁷ Such children have symptoms that resemble measles but are milder and of shorter duration. Such children usually have a significant antibody titer increase to measles virus, however, their clinical signs do not satisfy the minimum criteria for a case. Fortunately, it is felt that these modified cases may not be good measles virus transmitters and thus may be epidemiologically unimportant. However, more data on such cases are needed.

The second syndrome that occurs following measles virus infection is atypical measles. This syndrome sometimes occurs in children who were previously immunized with killed measles vaccine^{8,9} and rarely in children previously immunized with live measles vaccine.¹⁰ This syndrome, which is characterized by a maculopapular and petechial rash that begins on the extremities and proceeds cephalad, produces moderately severe disease including pneumonia. Atypical measles cases are occasionally clinically misdiagnosed as Rocky Mountain Spotted Fever (RMSF).¹¹ Although RMSF infections can be acquired in Florida, suspect RMSF in a teenager or young adult without a travel history to an endemic area should also have atypical measles placed high on the list of possible diagnosis.

The clinical diagnosis of measles can be confirmed serologically. The Central Laboratory Services of the Department of Health and Rehabilitative Service in Jacksonville will test acute and convalescent paired serum specimens for measles antibody by complement fixation (CF). The CF antibody begins rising 3-5 days after the onset of rash and reaches a peak at about 12-14 days after the onset of rash. Considering the present day low incidence of measles and the much greater combined incidence of other rash illness, serologic confirmation of any case of suspect measles is very important. Details about specimen submission can be obtained from hospital laboratories or the county public health department.

Comment • The 10-day hard red measles (rubeola) is not a benign disease. Although it was an almost universal affliction of childhood and most all persons infected recovered without sequella, it can cause significant complications. Otitis media and pneumonia are not infrequent complications and one in 1000 persons with measles develop encephalitis which can often lead to permanent residual brain damage. In many developing countries measles is still a killer just as it was in the United States at the turn of the century.

**Table 1. — Reported Measles Cases and Case Rates*
By Age, Florida, 1978-81.**

Age	1981		1978-81 Annual Average	
	Cases	Rate**	Cases	Rate
1	11	8.4	18	14.6
1-4	80	18.1	138	30.8
5-9	89	14.3	136	21.6
10-14	82	12.0	219	32.0
15-19	56	6.9	142	17.9
20-39	25	0.9	50	1.9
40-59	1	0.05	4	0.2
60+	1	0.04	2	0.1
UNK	0	—	22	—
Total	345	3.5	730	7.7

*Per 100,000 population

**Population figures for 1980 were used to calculate 1981 case rates

The nationwide measles elimination initiative has placed us on the threshold of eliminating indigenous measles transmission in the U.S., however, now is not the time to let down our guard. The Florida Medical Association Public Health Committee has endorsed Florida's measles elimination efforts. Practicing physicians can provide invaluable assistance to county public health departments and school officials in identifying and preventing measles by doing the following:

1. Immunize any child 15 months of age or older who has not received measles vaccine or the combination measles, mumps, rubella vaccine (MMR)
2. Recall for re-immunization all children who received measles vaccine before their first birthday or who were immunized before 1968. Reviewing records and establishing a recall system should be performed when appropriate.
3. If measles is in the community (three or more cases and evidence for transmission is established), for extra protection consider reimmunizing children who were immunized on or after their first birthday but before 15 months of age with the emphasis on children immunized close to their first birthday.
4. Provide immune globulin (IG) to susceptibles exposed to measles, especially children less than one year of age. However, immune globulin is indicated only if exposure is less than six days before.
5. Promptly report by telephone to the county public health department all measles and suspect measles cases.
6. After reporting a suspect case to the public health department, initiate action to obtain serologic confirmation of the diagnosis.

In addition, physicians who have responsibility for health care at summer camps should ensure that all camp employees are adequately immunized against measles (any persons born in 1957 or later who has no record of receiving measles immunization should be immunized) and that all children in attendance have adequate immunization documents. This is particularly true of children visiting from other countries who should be immunized against measles as soon as possible if they do not have adequate measles immunization documentation. It is also important that the camp director be made knowledgeable about the signs and symptoms of measles and the need to promptly report suspect cases to the camp physician and the county public health department.

Lastly, physicians attending children who are in day care centers should keep close watch on their immunization status and utilize required physical examinations of day care center attendees as an opportunity to immunize all children 15 months of age or older against measles (as well as against rubella and mumps).

Remarkable success against measles and other vaccine preventable diseases has been achieved through many community and governmental resources. Practicing physicians, community and volunteer organizations, school officials, and local, state, and federal governments have all participated in this achievement. Physicians having questions or comments regarding the measles elimination program or the new immunization law should address them to their local county public health department director or directly to the authors.

Acknowledgements

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Aside from enabling patients to fall asleep more quickly and sleep longer, Dalmane seldom causes morning hangover. Most Dalmane patients feel alert and refreshed when they awaken. In 53 paired-night clinical studies comparing Dalmane and placebo in 2010 insomniac patients with a variety of secondary diagnoses, most Dalmane patients awakened more alert and refreshed, and less groggy and drowsy, than on nights when they had taken only placebo.¹ In a double-blind crossover study of

42 patients in private practice, approximately three times as many patients reported feeling refreshed and alert upon awakening after a night on Dalmane (flurazepam/Roche) compared to placebo nights.² This difference was highly significant ($p < 0.001$). And a retrospective study of 2542 hospitalized patients who received Dalmane revealed only a 3.1% incidence of side effects.³

While residual effects from Dalmane therapy are infrequent, patients should be cautioned about drinking alcohol, driving or operating hazardous machinery after ingesting the drug.

Efficacy and safety in a broad range of patient types.

Over 2000 clinical trials involving more than 10,000 patients have shown that Dalmane patients fall asleep sooner, sleep longer and experience fewer nocturnal awakenings.⁴ The safety and efficacy of Dalmane have been demonstrated in medical and surgical hospitalized patients, in patients seen in office practice and in elderly patients.⁵⁻⁸ Since the risk of oversedation, dizziness, confu-

sion and/or ataxia increases with larger doses in the elderly, it is recommended that the dosage be limited to 15 mg.

Moreover, the efficacy and safety of Dalmane for the treatment of insomnia have been demonstrated in thousands of patients with a variety of primary medical conditions, including cardiovascular, neuropsychiatric, endocrine-metabolic, gastrointestinal, genitourinary, respiratory and musculoskeletal disorders.¹ Dalmane (flurazepam HCl/Roche) is contraindicated in pregnancy and in patients hypersensitive to the drug.

Avoids rebound insomnia upon discontinuation.

Rebound insomnia—a worsening of sleep beyond pretherapy levels after drug discontinuation—has been reported as a potential clinical problem with some hypnotics.^{9,10} However, this problem has not been reported with Dalmane. In eight out of eight sleep laboratory studies, there were no reports of rebound insomnia.¹¹ When you prescribe Dalmane, you can be confident of efficacy that enhances therapeutic progress. Your insomniac patients can be assured of a restful night, night after night—a good start for a good morning.

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.

Adults: 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

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Caribbean basin refugees:

The impact of Cubans and Haitians on health in South Florida

Antonio M. Gordon Jr., M.D.

During the past two years South Florida has been teaming with nearly a quarter of a million "uninvited" guests from the Caribbean basin who seem to be here to stay. Legally some are now called entrants but we still think of them as refugees. Although in the past ten years refugees from Indo-China, Haiti and Cuba have settled in South Florida, the greatest impact has been made by two entrant groups: the Cubans who arrived from the already famous bay in northwestern Cuba, Mariel, and the Haitians. What follows is an overview of the impact of these immigrants on our health system.

Despite the coverage given in the lay press to the refugees, many health questions remain unexplored. Has there been any increase in infectious diseases of public health importance? Can the incidence of crime and violence in South Florida be related to the influx from Mariel? Who is responsible for the medical care of refugees? Can the health problems of refugees be anticipated by considering the prevalence of problems in their countries of origin? These issues are discussed here through an assessment of the health statistics and features in the sources of refuges, the impact of these immigrants on public health in South Florida, their interaction with the curative health sector, and the incidence of crime and violence in this region.

Sources of Refugees • The two countries of interest in terms of refuges are obviously Cuba and Haiti. Cuba has a population of a little over 10 million and an area of 114,524 km² (87 persons per km²).¹ A diffuse and well orchestrated propaganda campaign has led many to believe that health in Cuba has improved since the island nation became part of the Soviet block.^{2,3} A marked decrease in infant mortality, disappearance of poliomyelitis, and an almost disappearance of bacillary dysentery have been reported.² The number of hospital beds (1 per 240 population), physicians (1 per 1,200 population)

and dentists (1 per 4,700 population) were reported in 1975.^{4,5} Immunization campaigns against polio, tuberculosis, diphtheria, pertussis and tetanus have been carried to the most remote areas of the country.⁶

Cubans should not be as fond of other statistics generated in Havana. They have the dubious honor of having the highest incidence of bacterial food poisoning (194/100,000) and infectious hepatitis (138/100,000) in the hemisphere.⁷ Two out of three men have unattended dental caries.⁸ The number of suicides is increasing and an appreciable number of Cubans have received medical attention for emotional and behavioral problems in Cuba.⁹

A diffuse and well orchestrated propaganda campaign has led many to believe that health in Cuba has improved since the island nation became part of the Soviet block.

Except for maternity and infant care, Cubans distrust their health care system.¹⁰ They are accustomed to political action groups (Committees for the Defense of the Revolution) going after them with vaccines and clinic appointments.² It follows that they may have difficulty in obtaining services through our health care facilities which rely on the individual's motivation to seek services and not on political action groups.

Haiti has a population which amounts to about half that of Cuba but the population density in Haiti is 133 persons per square kilometer.¹ Haiti does not advertise great gains in health and there is ample evidence that the country is the poorest in the Americas. In a recent survey, 73 percent of pre-school children were found to be malnourished.¹¹ Malaria is endemic in Haiti and travelers are advised to get prophylactic treatment when going to Haiti.¹²

The medical facilities in Haiti are sparse and scarcely staffed. There is one physician per 12,500 population, and the number of nurses is less than

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twice that of physicians. In Haiti there are less hospitals than in Dade County and one bed per 1,228 inhabitants.⁴

Public Health • Perhaps the greatest impact of the refugee influx in Dade County has been the increase in the incidence of active pulmonary tuberculosis (tbc). During the past three years the number of active tbc cases recorded by the Dade County Department of Public Health has increased by 37 percent of tbc cases in Dade. Several reasons can be considered with regards to the high incidence of tbc in Haitians, among these, the most prominent factor might be the incidence (11 per 10,000) of tbc in Haiti (Table II).¹⁷ Haiti has the highest incidence of tbc among the countries of the Caribbean basin.

Perhaps the greatest impact of the refugee influx in Dade County has been the increase in the incidence of active pulmonary tuberculosis (tbc).

Judging from the number of Haitians with tbc and assuming an incidence of tbc in the immigrants of 11 per 10,000, the number of Haitians in this area may be estimated to be more than 100,000. Official estimates place the Haitian population in South Florida at 30 to 70 thousand.¹⁴ The lack of accurate data on the number of Haitian entrants apparently results from the continued entry of non-documented immigrants.

In 1981 there was an epidemic of acute hemorrhagic conjunctivitis (AHC) in Florida. A total of 10,517 cases were reported by 19 counties.¹³ The epidemic began in Monroe County (southernmost Florida); the highest attack rates were observed among the overcrowded and the poor in northwest Miami. AHC had been reported in Cuba and the Caribbean earlier, and it is suspected that the refugee influx may have brought AHC to Florida. Official data from the Center for Disease Control on AHC in Florida is pending.

Table 1. — Cases of Active Pulmonary Tuberculosis In Dade County*

Year	TBC Cases In Non Haitians	TBC Cases In Haitians	Total TBC Cases
1979	315	18	333
1980	318	99	417
1981	284	169	453

*Courtesy of Dr. J. Cleveland, Dade County Department of Public Health.

Twenty-nine cases of malaria were reported to the Dade County Department of Public Health in 1981; among these there were six Haitians.¹³ Three cases of typhoid fever were documented among Haitians. All of the latter had been in Cuba up to three weeks earlier while their boats were being repaired. Two cases of dengue were reported in Dade in 1981. The epidemiology of malaria and dengue in Florida is obviously limited by the lack of vectors.

Individual Health • Both the Haitians and the Cubans have overwhelmed the curative health care facilities in South Florida. At one point in time in 1980, 25 daily admissions to the medical service of Jackson Memorial Hospital were reported to be Cuban refugees.¹⁵ Currently one Haitian mother goes into labor in Dade's County hospital every four hours.¹⁶ Similar loads have been common in the pediatrics service. The costs of attending refugees at Jackson Memorial Hospital are some five million dollars per month. Funds for undocumented entrants are non-existent.

Both the Haitians and the Cubans have overwhelmed the curative health care facilities in South Florida.

When individual cases are discussed the refugees can certainly impress any clinician. Consider for example a non-alcoholic adult refugee with normal GI function, including malabsorption studies, who has folate and B-12 deficiency. Don't underestimate primary malnutrition. What about adult men with iron deficiency anemia without GI pathology? Yes, the refugees have them also. Splenomegaly, malaise, fever or anemia should not suggest ordering this or that other scan. Instead look at a thick blood smear and check the latest reports on chloroquine resistant plasmodium. In case some tests are ordered routinely before completing evaluations, add stool for ova and parasite when the patient is a refugee. Many of us in South Florida have been reminded that massive peripheral lymphadenopathy can be the presenting sign of syphilis and tuberculosis. In case the pattern seem obvious, consider a 16 year old refugee with ten percent eosinophilia and wheezing. Six stools were negative for ova and parasite. Ah! He just had asthma and an allergic diathesis.

While detailed studies on the health of Haitians are now in progress, there have been several well

Table 2. — Incidence of Various Infectious Diseases in the U.S. and Selected Caribbean Basin Countries

	Cuba ¹	El Salvador ²	Haiti ¹	Nicaragua ²	U.S.A. ¹
Typhoid Fever per 100,000	4	38	22	30	1
Bacillary Dysentery per 100,000	1	—	7	73	1
Infectious Hepatitis per 100,000	138	62	5	23	2
Leprosy per 100,000	4	1	1	1	1
Measles per 10,000	25	17	1	4	2.5
Syphilis per 10,000	4	17	2	8	1
Gonococcal Infection per 10,000	8	13	3	14	45
Amebiasis per 10,000	2	7	4	18	1
Tuberculosis per 10,000	2	5	11	7	2

¹W.H.O. 1976

²W.H.O. 1975

documented reports on the health characteristics of the Mariel refugees (Table III). Asthma has been a common presentation among the Cubans.^{8,17} In Cuba, four percent of *all* hospital admissions are decompensated asthmatics.¹⁸ At Eglin Air Force Base in North Florida, 22 percent of hospital admissions were because of asthma.¹⁷ The prevalence of positive serology for syphilis among the Cuban refugees appears to be high; however, no increase in the incidence of venereal diseases has been recorded in South Florida. The vast majority of the refugees with positive serology were treated with penicillin at the immigration processing stations.

Crime, violence and psychopathology • The Mariel refugees are well known for their prevalence of criminals, social misfits and demented individuals. I cannot forget the face of a schizophrenic refugee I treated at Opa Locka soon after he arrived from Mariel. The patient had been taken from the Cuban equivalent of the South Florida State Hospital (an unfavorable comparison for S.F.S.H.), put into a boat and labeled "escoria," and there he was staring at me. He couldn't tell me why he came. His motivation for coming to Florida was not political like that of 79 percent of the "Marielitos", nor was it economic like that of twelve percent of them. It was not even a desire to reunite with his family like six percent of the 1980 Cuban refugees because he had no family. His motivation must have fallen under the heading of "miscellaneous". It seemed unfair to call this man a refugee, but there is no word in any language or precedent in history for sending this type of patient into a foreign country. He wasn't the only one either; there were more than 300 like him. These psychiatric cases, the near 2,000 felons and the overwhelming number of refugees in the boatlift, 124,799 of them, are prob-

ably the three best remembered features of this demographic explosion.¹⁹

The number of Mariel refugees who came to the attention of the Dade County coroner from April 1980 to March 1981 was 101.²⁰ Among these, there were 78 violent and accidental deaths (Table IV).

It is estimated that 298 Mariel refugees died during their first year of residence here.

This latter figure represents four percent of the 1,602 deaths in this category in Dade. It is estimated that 298 Mariel refugees died during their first year of residence here. The number of "Marielitos" in Dade is estimated at 90,000.¹⁴ These data yield a general mortality rate of 3.3 per 1,000, slightly lower than the general mortality rate in Cuba (5.8 per 1,000).¹ The Mariel refugees are slightly younger than Cuba's population which may explain the lower general mortality in the refugees.

Violent deaths are not uncommon in Cuba. The suicide rate in Cuba is 17.8 per 100,000 and reportedly increasing.¹⁹ The mortality rate in Cuba for the category of accidents, poisoning and violence ranges between 56.2 and 109 per 100,000.¹⁷ Interestingly, the number of "Marielitos" who died in Dade from these causes was 78 for 1980-81 (Table 4).²⁰ The corresponding mortality rate in this category is 84 per 100,000. Therefore, it seems that both general mortality and the death rate resulting from violence should have been expected from current Cuban mortality statistics. The mortality of "Marielitos" from violent causes outside of Dade, however, has been reported to be higher than 84 per 100,000.²¹

Table 3. — Summary of Health Characteristics of Newly Arrived Cuban Refugees (1980)*

Problem or Disorder	Frequency (%)
Marasmic malnutrition	
Adult men	32
Adult women	17
Children	24
Mild dehydration	27
Anemia	15
Decompensated obstructive lung disease	14
Psychiatric disorders	3
Hypertension	7
Traumatic injuries	7
Obesity	5
Positive VDRL	4
Degenerative joint disease	3
Peripheral lymphadenopathy of unknown etiology	3
Diabetes mellitus	2
Cirrhosis	1
Active tuberculosis suspects	0.5

*From references (8) and (17)

There are at least three etiologies for this high prevalence of violent deaths among the recent Cuban entrants. It is not unreasonable to propose that the society created by the Cuban Communist Revolution has been an important factor in the development of these individuals. Specifically, the 1980 Cubans are the product of more than 20 years of institutionalized terror.

The violent death rate of the Cuban refugees may be expected to be appreciably higher outside of Dade County. The refugees who settled initially in Dade found a more favorable cultural, social and economic structure than those who settled elsewhere.

A third etiologic factor for the high incidence of violent death is the prevalence of psychopathology among the refugees. In one study 28 percent of the refugees in Northern camps (Chaffee, Indiantown Gap, etc.) had signs of moderate to severe psychopathology.²² The prevalence of psychopathology among the original "Marielitos" who settled in Dade was some three percent.⁸

The impact of Mariel refugees on the prevalence of crime in South Florida can also be appreciated by

looking at the "Marielitos" who became prisoners in Dade. In December 1980 out of 163 Cuban nationals in the county jail, 103 were Mariel refugees;¹⁴ ten percent of the entire jail population was from the Mariel exodus. The most outstanding features of these jailed "Marielitos" were their history of being prisoners in Cuba (64 percent), and their prevalence of psychopathology (16 percent).¹⁴ Therefore, it seems reasonable to conclude that the frequency of violent deaths and crime among "Marielitos" correlates with their prevalence of psychopathology.

Conclusions • Refugees in numbers of up to 200,000 have stressed the health care systems of South Florida. The incidence of active pulmonary tuberculosis has increased in parallel with the influx of refugees. Health problems as well as mortality statistics among the refugees correlate well with the health and mortality statistics of the countries where refuges originated.

Careful attention to history, physical findings and simple laboratory tests may provide a diagnosis before technologically sophisticated studies are done.

The curative health sector has experienced well documented overcrowding conditions. The funds available to cover the health expenses of these immigrants are very limited in many cases and non-existent in others. The health expenses of immigrants who are not officially classified as refugees (according to the Refugee Act of 1980) present the most serious problem for Dade County. Asthma, parasite related disorders, late syphilis, primary malnutrition, and advanced tuberculosis are some of the diseases seen in refugees. Careful attention to history, physical findings and simple laboratory tests may provide a diagnosis before technologically sophisticated studies are done.

The problems leading to refuges are not the responsibility of local or state governments. These problems must be faced through multidisciplinary efforts to combat the social, economic, military, and political conditions in the Caribbean that lead to refuges. Effective methods must be employed in the health screening of undocumented entrants; otherwise, the incidence of diseases like tbc will continue to increase. Once refugees or entrants are

Table 4. — Characteristics of Violent and Accidental Deaths Among Cuban Refugees (April 21, 1980 to March 31, 1981)

Category	Cause of Death	# of Refugees	Age of Victim (mean, yrs.)	Total # of Refugees Per Category
Accident	Drowning	2	39.1	11
	Auto	8		
	Other	1		
Homicide	Gunshot Wound	52	30.0	57
	Stabbing	3		
	Blunt Injury	2		
Suicide	Gunshot Wound	6	38.9	10
	Burns	2		
	Other	2		

in Florida, they must be cared for by both public and private health care providers. Availability of Federal funds to care for the refugees or entrants conceptually belongs with the program proposed, by the President, for the Caribbean basin.

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NIH consensus development conference: Computed tomographic scanning of the brain

A Consensus Development Conference held at the National Institutes of Health November 4-6, 1981 reviewed scientific evidence related to computed tomographic scanning (CT) of the brain.

At NIH, Consensus Conferences bring together research investigators, practicing physicians, representatives of consumer and special interest groups and others to make a scientific assessment of medical technologies and to seek agreement on their safety and effectiveness. After hearing data presented by experts in CT scanning and considering audience discussion, a Consensus Panel of specialists and generalists issued a statement addressing key issues relating to CT scanning of the brain. Following is a summary of that statement:

CT scanning of the brain is a safe, accurate, and powerful tool in the primary diagnosis of brain tumors, brain hemorrhage, major head injury, and certain brain infections. CT scanners have been a major factor in decreasing deaths, especially in severe head injury and brain abscess, and the presence of these conditions clearly calls for the diagnostic assistance of the CT.

While there are numerous indications for the use of CT, it should not be employed as a "routine screening procedure" when patients show little likelihood of having structural disease such as in cases with minor head trauma or simple headache.

Among the indications for use of CT are when there is suspicion of arteriovenous malformations, hydrocephalus, herpes simplex encephalitis, parasitic infestations, progressive degenerative disease of the brain and intracranial tumors. In primary brain tumors, CT has resulted in the detection of smaller lesions, lower death rates following surgery, and decreased time in the hospital.

CT usually will differentiate between ischemic and hemorrhagic intracranial lesions — helping the physician to select appropriate medical or surgical therapy. And CT is helpful in identifying potential structural causes of complex partial or focal epileptic seizures. CT also is an important clinical tool in pediatric neurology that should be used to evaluate undiagnosed coma and other neurological symptoms.

Although CT does carry potential hazards, including a small risk of adverse reactions to contrast material — if used — the procedure is "remarkably safe". The amount of radiation produced by the CT is comparable to or less than that emitted from many other routine diagnostic procedures, including dental X-rays. Physicians should, however, use special care in ordering multiple scans for children since "the effects of repeated cumulative low-level radiation doses to the immature, developing brain are yet unknown."

Despite its wide use, CT "may not be sufficiently available for the public to derive the full benefit of its potential." Evidence indicates an insufficient number of the instruments in some large metropolitan areas, in medically underserved areas, and in sparsely populated regions which experience a high incidence of head trauma.

Copies of the full Consensus Statement on CT Scanning of the Brain may be obtained from the Office for Medical Applications of Research, Building 216, National Institutes of Health, Bethesda, Maryland 20205.

Editor's note: The Journal requested Jacob Green, M.D., Jacksonville, to review this report. His comments are given below.

To the Editor: Thank you for your letter of May 12th, 1982 requesting my comments concerning the NIH Consensus Development Conference on CT scanning of the brain. I find it is a well done document. There are, however, some developments which have already taken place since November of 1981 which have changed the complexion of this report significantly. To which I would like to make the following comment.

The report of the NIH Consensus Development Conference on CT Scanning of the Brain is received with great acclaim. However, it does not appear to emphasize enough the significant risk of routine CT scanning with the use of intravenous contrast enhancement which appears to be the rule rather

than the exception in most centers. This goes contrary to the American Society of Neuro-Imaging Guidelines which suggests that intravenous iodine contrast enhancement (usually 50 to 100 cc of Renographin 60 or other similar preparation) be reserved for those with probable enhancing lesions. This is to state that the routine headache disorder which the physician wishes to exclude intracranial neoplasm not be contrasted.

The comparison of this test to positron emission computed tomography (PET scan) is also interesting in that positron emission tomography requires the presence of a cyclotron in that the medium used for enhancement lasts only for two minutes. Most general hospitals cannot afford a cyclotron.

The most important statement in this document is nuclear magnetic resonance (NMR) as a technique that has "yet to be established" which is clearly one in which I find some room for challenge and controversy. Most experts including Dr. William Olendorf, the senior V.A. investigator in this field, et al at the May 1982 American Academy of Neurology meeting

have stated that NMR (or perhaps better called magnetic resonance imaging) could clearly evolve into a situation in which CT scanners will be all "on a junk pile in five years".

Those of us who have been around neurology for a number of years still rely upon the time tested tool of history and clinical examination as the most important. EEG is still an excellent measure of brain function. Evoked potentials further define the ability to diagnose pathway lesions of the peripheral nerve through to the cortex in a new and wide variety of cases. While this statement concerning CT scan appears to be reasonably accurate for November of 1981, the development and progress of magnetic resonance imaging has clearly eclipsed the CT scan and I along with other senior neurologists now see that the CT scan may well be heading in fact for the junk pile.

*Jacob Green, M.D.
Past President
Florida Society of Neurology*

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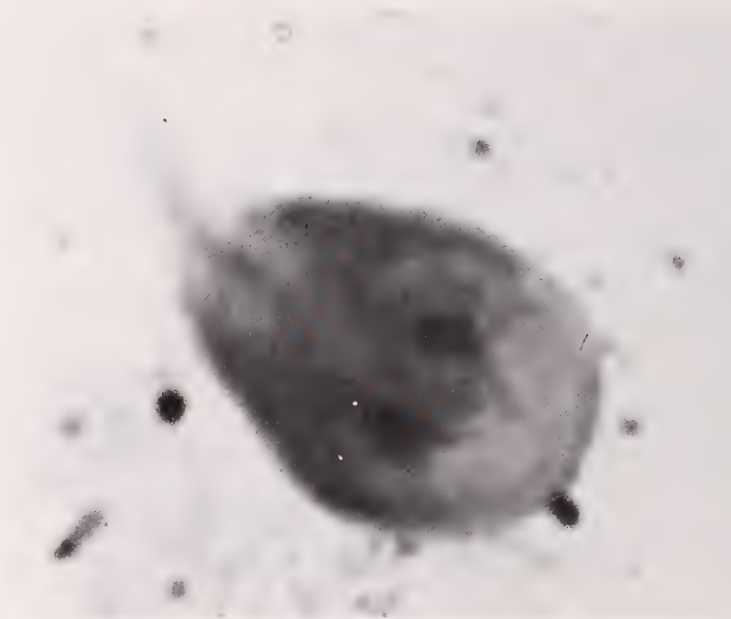
Those parasites that live primarily in the duodenum or bile ducts often are more readily seen in the duodenal contents than in the stool. These include *Giardia lamblia* (motile trophozoites), *Strongyloides stercoralis* (larvae and/or eggs in advanced stages of development), *Clonorchis sinensis* (eggs), *Fasciola hepatica* (eggs), *Trichostrongylus orientalis* (eggs), and *Isospora* (coccidia).

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Chronic Diarrhea caused by anaerobic and aerobic bacteria in infants and children was easily identified using the Entero-Test. The string test was comparable to or better than duodenal aspirate in all cases.



Giardia lamblia

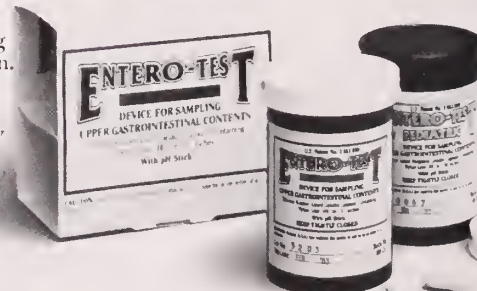
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FLORIDA****Director: Maxwell McKenzie, M.D.****Program Coordinator: Jose S. Bocles, M.D.**

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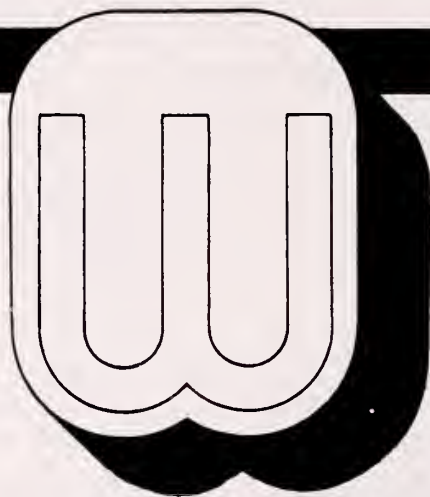
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One Hundred Eighth Annual Meeting Florida Medical Association, Inc. Hollywood, May 5-9, 1982

President's Address Sanford A. Mullen, M.D.

Ladies and gentlemen of the Florida Medical Association — members, wives, husbands, children, FMA and county medical society staff members, guests and friends:

It is my great honor to have served as your President for the past year. I would first like to thank the members of the House of Delegates who elected me to this position two years ago. And I would like particularly to thank Dr. T. Byron Thames, my predecessor, under whose outstanding leadership I served as President-Elect for a year before being installed as your President a year ago. Dr. Thames was a great teacher when I was President-Elect and has been a great supporter while I have been President.

During my term as President I have been privileged to work with a very talented and effective group of officers and members of the Board of Governors. I would like to comment briefly about one member of the Board of Governors, Mr. James E. Deming. Jim is a senior medical student at the University of Miami School of Medicine. The FMA bylaws provide that the President, with Board approval, may name a medical student from a Florida medical school to the Board of Governors. Jim was our selection this year and has done a superb job in giving us the viewpoint of medical students, those important people who will — in a few years — have the responsibility of providing leadership to the Florida Medical Association.

Support by Members • I would like also to thank the FMA members of the various councils and committees making up the organizational structure of the FMA. Countless hours were devoted to the FMA by these dedicated individuals.

The FMA has been blessed with an outstanding staff, both in the headquarters office in Jacksonville and in the regional offices in Miami, Winter Park, Tallahassee and Tampa. Our Executive Vice President,

Dr. W. Harold Parham, has continued to do his job in a most exemplary way. During the past year Harold's involvement with the FMA has begun to be reduced gradually as your Board of Governors plans for his retirement as Executive Vice President in 1984. As Harold's responsibilities are being lessened, Mr. Donald C. Jones, our Executive Director, is being given ever increasing responsibilities. This year he has been



Sanford A. Mullen, M.D.

designated as our Chief Executive Officer. Don and I have traveled widely through the State and have worked together closely throughout the year. He has demonstrated fully to me that he justifies his new title as our CEO. I commend him for his dedication to his duties and his overall effectiveness for the Florida Medical Association.

Donald S. "Scotty" Fraser, our Associate Executive Director, has been the Executive Director of FLAM-PAC and the director of our legislative activities for many years. He continues to do his unusual fine job. Scotty's work in the recently concluded session of the Florida Legislature was excellent. He is now busily engaged in planning for the political campaigns looming ahead in the near future. Mr. John E. Thrasher, our Chief Legal Counsel, has maintained his quietly effective role in leading us through the many minefields of legal problems that we encounter nearly every day. There are many other capable and dedicated men and women of the FMA staff who give all of us great support on a day-to-day basis. I wish I could name all of them for you, but time does not permit.

County Society Support • I would be remiss in my responsibilities if I did not mention the support given to the FMA in general and to me in particular by the executives and staffs of the county medical societies throughout the state. Without exception, I have had excellent support from the county medical societies throughout the year. Let me pause briefly to thank all of you who have done so much to make the responsibilities of the presidency so much more manageable.

During my year as your President, I have had the opportunity to visit many county medical societies and specialty groups. It has been a truly enriching experience for me to see at first hand the high level of medical practice throughout this great state. It is fair to say that good medical care is available in all of our counties by the efforts and talents of the members of the FMA working in their local communities. I am proud to be your leader.

During the next few days you will have the opportunity to examine in detail the work of the Association. You will be able to study the financial status and learn everything you want to know about the FMA. Your officers, Governors, Council and Committee Chairmen, and staff are here to give you the answers. I won't try to give you the details of the actions of the FMA during the past year. You can work out all of that information at the Reference Committees and through informal discussions. Of course, I shall be available to answer your questions to the best of my ability.

We know that we have many challenges facing us in the months ahead. All of us are concerned about professional liability. The escalation of numbers of suits and levels of awards poses a major threat to the

practice of medicine. The FMA has been involved in professional liability insurance since 1929 with a much greater degree of involvement since 1973. Each of you is urged to read the report of the FMA Committee on Professional Liability as it was published in the November 1981 issue of *The Journal of the Florida Medical Association*. A copy of that report is included in the 1982 House of Delegates Handbook. As you are undoubtedly aware, we plan to make a major effort at the 1983 Session of the Florida Legislature to bring legislative relief to this problem which has become a national problem for all of society — not for the medical profession alone.

A Graver Threat • In no way would I minimize the importance of the problems we face in professional liability. Certainly a major effort on our part is needed to solve this problem. I am confident that we will ultimately be able to solve the problem of professional liability. But to me, we face a much graver threat than the threat posed by professional liability. A consideration of my perception as to the greatest threat facing medicine will provide the major part of the comments I make to you today.

I believe that the greatest threat facing medicine today is the attempted fragmentation of the practice of medicine by those who would try to gain access to some or all parts of the practice of medicine by legislative or regulatory fiat without bothering to take the time and expend the effort necessary to earn the M.D. degree. At times members of the medical profession can unknowingly give support to this fragmentation by failing to recognize that the intrusion into one small area of medical practice poses a threat to all of us. When the problem of doctors not recognizing this serious threat is analyzed, it becomes understandable because of the way our profession has developed in recent years.

A century ago medical practice had advanced little beyond the practices of ancient Rome, Greece or Egypt. There was relatively little doctors could do to help persons with injuries and illnesses. Knowledge of bacteria and the infectious diseases was just emerging. Medicine men touting the virtues of snake oil and other magical nostrums were in vogue. Most medical schools were a disgrace. The practice of medicine was far from the honored profession we know today.

The Flexner Report • Although many factors influenced the changes in medical practice, most medical historians agree that the issuance of the Flexner Report in 1910 was the turning point in the development of scientific professionalism in the education of doctors and in the medical profession itself. Prior to that time only a handful of medical schools had given any type of effective medical education to their students. Following the Flexner Report there was a virtual explosion in the development of

quality medical schools. As quality medical schools came into being, their products — the doctors — spread over our country. This new breed of doctors conducted clinical and basic research that produced the wonders in medicine that our country has come to take for granted.

For most of the early part of this century there was only a very limited degree of specialization in medical practice and most doctors had a similar type of practice. Practicing doctors, as a consequence, worked closely together and they were generally a unified group. But as time went on, specialization became desirable, appropriate, and even necessary because no single medical doctor could hope to be competent in all fields. Doctors became more interested in their special areas of medical practice. They took much less interest in their colleagues practicing in other fields. As doctors became more specialized they frequently trained non-physicians to help them. This was largely to the benefit of their patients because this enabled the doctors to concentrate on procedures that only they could perform.

Allied Health Professions • The development of these assistants led to a proliferation of the groups we now call allied health professions. In addition to those allied health professions developed by physicians, other forms of health therapists have survived since the pre-Flexner days and still others have developed since that time. The development and proliferation of the allied health professions has led inevitably to problems for the public as well as for the medical profession. Members of many of the allied health professions have concluded that they should be allowed to carry out their activities without any control being exercised by the medical profession.

The old axiom that a little knowledge is a dangerous thing has never been more clearly shown than in the demands of some of these allied professionals to be free of medical control. Many of these groups have gone to the legislatures throughout the country to have their demands satisfied. Their theme in the legislatures varies in some ways, but the basic thrust is always the same — they want to be free, in the American tradition of freedom, to practice their profession without, as they phrase it, "the oppressive restraints of the medical profession who are against us because our freedom poses an economic threat to medical doctors." Almost never is there any mention of the fact that the quality of medical care to the public may very well be compromised by removing restraints on the practices of allied health professionals.

As the trend of proliferation of independent practice by allied health workers is allowed to continue, the public will certainly be the loser. It appears to me that the very scientific excellence that has been

developed in medicine will be lost if we return to the pre-Flexner era of hucksterism and snake oil peddlers.

Of course, good medical education and research will undoubtedly continue at the medical schools in this country, but the well established and rapid permeation of these high standards and the prompt introduction of new information and improved techniques to virtually every community will be threatened, as the public is led to believe that these allied health professionals are just as well educated and just as effective as medical doctors. No longer will the public believe that medical doctors are the essential part of good medical care.

Hazards of Fragmentation • This concept of the hazards of fragmentation of the practice of medicine may sound far-fetched. But one has only to review the activities of the 1982 Florida Legislature to realize the validity of such a concept. The Legislature overrode the Governor's veto of a law that will now allow non-proven treatments for cancer to be used on an unsuspecting and gullible public grasping at straws in an effort to obtain cures by treatments that have no scientific validity and are doomed to failure. The Legislature gave serious consideration to enacting a law that would require all licensed chiropractors to be given staff privileges at all Florida licensed hospitals. Laws were considered to provide licensing boards and practice privileges to naturopaths and homeopaths. Optometrists nearly gained the right to prescribe drugs in a virtually unlimited fashion. Certain nurses worked actively to gain the right to practice medicine without any controls by the medical profession. You can be sure that many other groups are waiting for an opportunity to move on the medical profession.

There is no doubt that the American public would be the tragic loser if the intrusion of these health related groups is allowed to fragment the medical profession. I am certain that only medical doctors can be the captain of the health care team. No other individuals have the background and experience to be qualified to assume this role, but it is a position we must work to retain. These other groups and the public must come to understand that quality medical care can only be assured if medical doctors head health care efforts. Allied health workers cannot practice without medical control if quality medical care is to be assured.

Responsible Action • This position of leadership requires responsible action on our part. We must earn our leadership role every day by our actions. We must work with all legitimate allied professionals. We must listen to their suggestions. We must be ever alert to the need for change. We can never retain our leadership by taking the position that medical actions must be performed in the manner we prescribe just because we are medical doctors. We must be able to do more.

We must be able to give logical reasons for our plans and actions. By this type of leadership we will be recognized by all concerned as the qualified leaders and there will be no need for us to demand the leadership role.

and there will be no need for us to demand the leadership role. It will be willingly given to us so long as we justify it by our actions.

The Legislature will be acting in the next session and in all following sessions to determine the role of the medical profession in the years ahead. Our conduct in general and our ability to speak and act as a unified group will play a major role in legislative actions.

I would like to paraphrase some of the remarks made by Mr. Newton M. Minow at the Leadership Conference of the American Medical Association in February of this year. Mr. Minow is an attorney who has represented the AMA in many important legal battles in recent years. He is a distinguished individual who has given many years of service in the private sector as a Trustee to several universities and medical institutions, as well as to the public sector which he served as Chairman of the Federal Communications Commission. Mr. Minow quoted Justice Oliver Wendell Holmes who said, "The life of a law is not logic; the life of a law is history." Thomas Jefferson was also quoted by Mr. Minow as saying, "I am not an advocate of frequent changes in the law or frequent changes in constitutions, but as conditions change, the law must change because otherwise we would require a man to wear a coat that fit him as a boy."

Writing the Laws • Mr. Minow expressed the concept that, in effect, physicians are themselves writing the laws of the near and distant future by the way they practice. The laws affecting physicians and their ability to practice medicine will depend on how society values and perceives physicians.

According to Mr. Minow, if the public looks upon physicians and surgeons, as you and I see them, as individuals selflessly committed to healing the sick and comforting the suffering with compassion and care for their emotional and psychological needs and their financial circumstances, then the law will smile on the practice of medicine in the future. But, on the other hand, if the public comes to regard physicians as highly trained men and women who are in practice only to maximize their income and have little personal interest in the needs of those whom they meet and they treat, then the law will frown on physicians and the implications for the independent practice of medicine will be bleak.

At the same time the legal and legislative climate for the activities of medical associations in the 80's and 90's will depend largely on the attitudes and perceptions that society has of our associations. It is obvious to all of you that the public views physicians as individuals different from how they view physicians when they organize themselves together. If medical associations are perceived as public spirited groups of physicians working together to advance the interests of their patients, improve the public health and the quality of medical care, a favorable legal and legislative environment will follow. If, by contrast, such Associations are perceived — as some government officials see them — as co-conspirators intent on raising their profits and suppressing competition, then no one can help them very much. To me these comments by Mr. Minow can be readily applied to our medical practice in Florida.

Community Involvement • It is hoped that my remarks concerning the threat of fragmentation of medical projects will make it obvious that doctors must be involved in their own communities. Doctors and their families must be a part of every worthwhile community activity. By their actions doctors must make certain that their honored community status is justified. Doctors must work together and realize that a threat to one group of doctors is a threat to all.

Let us work together and discuss our differences and come to a conclusion based on the will of the majority so that we can speak with a single voice. Together the family of medicine as exemplified by the county medical societies, by the Florida Medical Association, by the American Medical Association and by our state and national specialty societies, has the ability to continue the steady development of quality medical care that our country has experienced during the 20th Century. We can prevent the intrusions of the cultists and all inadequately prepared practitioners. We must work closely in a leadership role with legitimate allied health professionals. The opportunity is now available to us. If we seize this opportunity in a proper and responsible manner, we can maintain quality medical care and continually improve it for everyone. And, after all, that is the reason the Florida Medical Association has continued to provide medical leadership to Florida for more than a century.

● Dr. Mullen, P.O. Box 2921, Jacksonville 32203.

First House of Delegates

The First House of Delegates convened at 4:30 p.m. on Wednesday, May 5, 1982 in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, with James B. Perry, M.D., Speaker of the House, presiding.

The House rose for the invocation which was given by Jere W. Annis, M.D., and remained standing for the pledge of allegiance.

Dr. Perry announced the membership of the Credentials Committee:

Daniel L. Seckinger, M.D.
Samuel M. Atkinson, M.D.
Richard A. Bagby, M.D.

The Delegates were reminded that they must register with the Credentials Committee before this and every meeting of the House of Delegates.

Dr. Seckinger, Chairman of the Credentials Committee, announced that 215 Delegates were present, representing 35 component societies, which constitutes a quorum.

A motion carried to seat Delegates.

Delegates

ALACHUA — O. Frank Agee, M.D.; Mark V. Barrow, M.D.; Douglas O. Jenkins, M.D.; [Absent — Thomas D. Bartlev, M.D.; William B. Deal, M.D.; William T. Hawkins, M.D.; Diane M. Zabak, Student Delegate]
BAY — James T. Cook III, M.D.; [Absent — Joe Bob Harbison, M.D.]
BREVARD — James E. Carter, M.D.; Walter A. Cerrato, M.D.; Michael J. Foley, M.D.; Francis S. Pooser, M.D.; Paul J. Popovich, M.D.; Ovidio E. Vitas, M.D.
BROWARD — Robert L. Berger, M.D.; Robert J. Brennan, M.D.; Andre S. Capi, M.D.; Arthur L. Eberly, M.D.; Kenneth H. Farrell, M.D.; Paul A. Flaten, M.D.; Stanley S. Goodman, M.D.; William C. Hartley, M.D.; George P. Messenger, M.D.; Alexander E. Molchan, M.D.; Jerry D. Moore, M.D.; Donald J. Plevy, M.D.; Thomas F. Regan, M.D.; Joseph M. Sachs, M.D.; Richard D. Schultz, M.D.; Peter A. Tomasello, M.D.; Anthony J. Vento, M.D.; Juan S. Wester, M.D.; [Absent — Bruce B. Burgess, M.D.; Phillip A. Caruso, M.D.; Willis N. Dickens, M.D.; Theodore W. Hahn, M.D.; John M. Harper, M.D.; Wilbur F. Helmus, M.D.; David C. Lanc, M.D.; Robert J. Lenar, M.D.; Herbert M. Todd, M.D.; Harry B. Weinberg, M.D.]
CAPITAL — Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Robert N. Webster, M.D.
CHARLOTTE — Thomas R. Civitella, M.D.; Joseph R. Goggin, M.D.; Jaime Torner, M.D.
CITRUS-HERNANDO — Wilburn R. Jenkins, M.D.; Clinton J. McGrew, M.D.
CLAY — Hinson L. Stephens, M.D.

COLLIER — Charles J. Montgomery, M.D.; Virgil A. Ponzoli Jr., M.D.; Joseph F. Sullivan, M.D.

COLUMBIA — Barney E. McRae, M.D.

DADE — Edward R. Annis, M.D.; Jerome Benson, M.D.; Robert E. Boyett, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; Victor O. Calderin, M.D.; William P. Calvert, M.D.; Edmund Cava, M.D.; Richard C. Clay, M.D.; Vincent P. Corso, M.D.; DeWitt C. Daughtry, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Charles A. Dunn, M.D.; Augusto Fernandez-Conde, M.D.; Miguel Figueroa, M.D.; N. Ralph Frankel, M.D.; George R. Gage, M.D.; Richard L. Glatzer, M.D.; Alan S. Graubert, M.D.; Julian H. Groff, M.D.; Joseph Harris, M.D.; Walter C. Jones III, M.D.; Norman M. Kenyon, M.D.; Melvin A. Klein, M.D.; Warren Lindau, M.D.; Simon E. Markovich, M.D.; Roberto L. Maury, M.D.; William T. Mixson, M.D.; Charles A. Monnin Jr., M.D.; Miguel A. Mora, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Jorge R. Pena, M.D.; Pedro A. Ramos, M.D.; William I. Roth, M.D.; Daniel L. Seckinger, M.D.; Everett Shocket, M.D.; M. David Sims, M.D.; Margaret C.S. Skinner, M.D.; Douglas Slavin, M.D.; Marvin B. Slotkin, M.D.; Samuel P. Stokley, M.D.; Charles F. Tate, M.D.; Thomas B. Turner, M.D.; Osvaldo D. Valdes, M.D.; Edgar W. Webb, M.D.; Harold H. Weiner, M.D.; Steven M. Weissberg, M.D.; Bruce W. Weissman, M.D.; Leo Whitman, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D.; James E. Deming, Student Delegate; [Absent — Carlos G. Llanes, M.D.; Richard D. Miller, M.D.; William E. Reimer, M.D.; Walter W. Sackett, M.D.]

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Samuel J. Alford Jr., M.D.; William P. Booras, M.D.; Yank D. Coble, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; Charles P. Hayes Jr., M.D.; Benjamin A. Johnson, M.D.; Charles W. Lewis, M.D.; Faris S. Monsour, M.D.; Daniel B. Nunn, M.D.; Guy T. Selander, M.D.; Robert H. Threlkel, M.D.; James W. Walker, M.D.; William D. Walklett, M.D.; [Absent — Gaston J. Acosta-Rua, M.D.; Mohamed H. Antar, M.D.; William J. Garoni Jr., M.D.; John F. Lovejoy Jr., M.D.; Charles B. McIntosh, M.D.]

ESCAMBIA — Richard H. Ciordia, M.D.; Eric F. Geiger, M.D.; Charles J. Kahn, M.D.; Theodore J. Marshall, M.D.; Charles F. McConnell, M.D.; F. Norman Vickers, M.D.

FLAGLER — [Absent — John M. Canakaris, M.D.]

FRANKLIN-GULF — Joseph P. Hendrix, M.D.

HIGHLANDS — Luis M. Pena, M.D.; Robert T. Rengarts, M.D.

HILLSBOROUGH — Richard A. Bagby, M.D.; Francis C. Coleman, M.D.; Richard G. Connar, M.D.; Emilio D. Echevarria, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Richard S. Hodes, M.D.; Robert G. Isbell, M.D.; Victor H. Knight Jr., M.D.; Thomas E. McKell, M.D.; Robert J. Qualey, M.D.; Ralph E. Rydell, M.D.; Ronald L. Seeley, M.D.; William M. Trice, M.D.; James A. Winslow Jr., M.D.; Alexander S. Gross, Student Delegate; [Absent — Robert E. McCammon, M.D.]

INDIAN RIVER — Donald L. Ames, M.D.; [Absent — Ferdinand F. Becker Jr., M.D.]

LAKE — Frederick C. Andrews, M.D.; Joseph E. Holland, M.D.; Robert H. Hux, M.D.

LEE — Cecil C. Beehler, M.D.; Larry P. Garrett, M.D.; Francis L. Howington, M.D.; H. Quillian Jones Jr., M.D.; Stephen R. Zellner, M.D.

MADISON — [Absent — William J. Bibb, M.D.]

MANATEE — Thomas R. Busard, M.D.; George C. Gallati, M.D.; Julian Giraldo, M.D.; Michael G. Ryan, M.D.

MARION — C. Brooks Henderson, M.D.; James L. McLaughlin, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D.; Guy R. Hopper, M.D.

MONROE — [Absent — Robert D. Carraway, M.D.; Ronald H. Chase, M.D.]

NASSAU — [Absent — E. Trier Morch, M.D.]

OKALOOSA — David R. Arrowsmith, M.D.; Samuel M. Atkinson Jr., M.D.

ORANGE — Edward Ackerman, M.D.; William E. Hoffmeister, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; James F. Richards Jr., M.D.; Edward W. Stoner, M.D.; John P. Taggart, M.D.; T. Byron Thames, M.D.; Robert B. Trumbo, M.D.; Cecil B. Wilson, M.D.; [Absent — Clarence H. Brown III, M.D.; Clarence M. Gilbert, M.D.; Charles T. Price, M.D.]

OSCEOLA — Gilberto Perez, M.D.

PALM BEACH — Vernon B. Astler, M.D.; Elizabeth J. Barice, M.D.; Richard C. Cavanagh, M.D.; Ralph R. Eastridge, M.D.; Lee A. Fischer, M.D.; J. Russell Forlaw, M.D.; Luis R. Guerrero, M.D.; James M. Johnson, M.D.; V.A. Marks, M.D.; Richard B. Moore, M.D.; William J. Romanos Jr., M.D.; James F. Smith, M.D.; Joel F. Smith, M.D.; Ben R. Thebaut Jr., M.D.; Milton R. Tignor Jr., M.D.; Dick L. Van Eldik, M.D.

PANHANDLE — James T. Cook Jr., M.D.; Karl S. Franz, M.D.

PASCO — Kong D.L. Chiang, M.D.; David A. Johnson, M.D.; [Absent — Vincent G. Cotroneo, M.D.]

PINELLAS — Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; John M. Hamilton, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; Morris I. LeVine, M.D.; Jack A. MacCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; William H. Schmid, M.D.; Bruce P. Smith, M.D.; [Absent — John F. Lee, M.D.; John M. Thompson, M.D.; Walter H. Winchester, M.D.]

POLK — Ronald W. Case, M.D.; John W. Grotfelty, M.D.; Wiley E. Koon, M.D.; Thomas E. McMicken, M.D.; John C. Moore, M.D.; David Stoler, M.D.; [Absent — Thomas M. Caswall, M.D.; Saul B. Gerber, M.D.]

PUTNAM — [Absent — Roy E. Campbell, M.D.]

ST. LUCIE - OKEECHOBEE — [Absent — Charles R. Cambron, M.D.; William H. Meyer Jr., M.D.]

SANTA ROSA — David B. Young, M.D.

SARASOTA — John N. Carlson, M.D.; Kenneth C. Kiehl, M.D.; Martin F. Mihm, M.D.; Douglas R. Murphy, M.D.; Franklin H. Pfeiffenberger, M.D.; Richard C. Rehmyer, M.D.; Karl R. Rolls, M.D.

SEMINOLE — Luis M. Perez, M.D.; Frederick J. Weigand, M.D.

SUWANNEE-HAMILTON-LAFAYETTE — [Absent — Alex Kish, M.D.]

TAYLOR — John H. Parker, M.D.

VOLUSIA — Grandy B. Barnard, M.D.; Charles R. DeArmas Jr., M.D.; Remigio G. Lacsamana, M.D.; Robert W. Lankford, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.

WALTON — [Absent — Howard F. Currie, M.D.]

WASHINGTON — [Absent — Muhammad I. Zafar, M.D.]

SPEAKER OF THE HOUSE — James B. Perry, M.D.

VICE SPEAKER — Franklin B. McKechnie, M.D.

once been seated. **The Bylaws require that delegates fill out attendance cards at each meeting of the House of Delegates in order to be credited in attendance,** and further, the chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Reports and resolutions that were received before going to press are included in this Handbook. Delegates are urged to study them carefully before they are introduced in the House. Wherever possible, it is requested that resolutions and supplemental reports be forwarded to the Association's Headquarters Office by April 23 for duplication and distribution to the delegates.

Your attention is called to the format of the annual meeting, where the Reference Committee meetings will be held in the morning following the First Meeting of the House. All reports and resolutions will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates. All members who are interested in any committee report or resolution should attend the Reference Committee meetings where a full discussion will take place. Council and committee chairmen are respectfully requested to be present and discuss their respective reports. All members of Reference Committees are urged to study carefully the reports and resolutions referred to them. The chief purpose of the Reference Committees is to allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates. Members may request the Reference Committee chairmen to defer items in which they are interested in order that they may be present to discuss the subject.

All resolutions **must have a sponsor present before the Reference Committee.** Resolutions must be filed by 12:00 noon on the day of the First Meeting of the House of Delegates, typewritten and in proper form. The resolutions so presented will be available for distribution by the time the First House convenes. Only the "Resolved" portion of the resolutions will be adopted as policy.

All Reference Committee reports will be duplicated and available to the delegates at the Registration Desk on Saturday morning. We trust these provisions will result in an efficient and informed House of Delegates.

All reports and resolutions included in this Handbook, (as well as those which will be in the Delegates' Packets, and the reports of the Reference Committees) have been printed on colored paper for easy reference. This color code is as follows:

Reference Committee No. I — Green
Reference Committee No. II — Buff
Reference Committee No. III — Blue
Reference Committee No. IV — Pink
Reference Committee No. V — Goldenrod

According to our Bylaws, nominations and seconding speeches shall be limited to a maximum of two minutes each. If additional information needs to be presented, it should be duplicated and distributed to members of the House.

Your Speaker and Vice Speaker are available at any time to help in any way in the preparation of resolutions or in any capacity in which they might help any member of the Florida Medical Association.

James B. Perry, M.D., Speaker
House of Delegates

Franklin B. McKechnie, M.D., Vice Speaker
House of Delegates

A motion carried to adopt the Rules and Order of Business as listed in the Handbook:

Information for Delegates

The Rules and Order of Business for the House of Delegates are included in this Handbook.

Delegates and alternates whose names appear in this Handbook have been certified by their county medical societies. Our Bylaws do not permit an alternate to serve for a delegate who has



James B. Perry, M.D., Speaker of the House of Delegates, presides at the opening session of the House. At head table are (left to right): W. Harold Parham, D.H.A., Executive Vice President; T. Byron Thames, M.D., Immediate Past President; Sanford A. Mullen, M.D., President; Dr. Perry; Franklin B. McKechnie, M.D., Vice Speaker; Robert E. Windom, M.D., President-Elect; Gerold L. Schiebler, M.D., Vice President; Luis M. Perez, M.D., Secretary; and J. Russell Forlaw, M.D., Treasurer.

A motion carried to adopt the Minutes of the 1981 House of Delegates as published in the July 1981 issue of *The Journal of the Florida Medical Association*.

The Speaker introduced the officers of the Association: Franklin B. McKechnie, M.D., Vice Speaker; Robert E. Windom, M.D., President-Elect; Gerold L. Schiebler, M.D., Vice President; Luis M. Perez, M.D., Secretary; J. Russell Forlaw, M.D., Treasurer; Sanford A. Mullen, M.D., President; T. Byron Thames, M.D., Immediate Past President; W. Harold Parham, D.H.A., Executive Vice President.

Dr. Perry advised that during the past year a number of FMA members had departed this life. In memory of these physicians, roses had been placed in the vases at each end of the Speaker's podium. Dr. Perry asked that the House observe a moment of silent prayer in respect and memory of these members.

Remarks — Speaker of the House

Mr. President, Officers of the Association, Delegates, Honored Guests, fellow physicians, ladies and gentlemen: It is my privilege and honor to address you on this date, the opening session of the 108th Annual Meeting of the Florida Medical Association. A special session was held this morning, which I believe, sets the tone of the House and the feeling of some urgency in a milieu of unreality that permeates our organization and our entire society.

In an effort to create a modicum of organization out of a climate of chaos our Association functions under strict rules of law and discipline which usually persevere and which I should like briefly to overview.

FMA By-laws require delegates to fill out attendance cards at each meeting of the House of Delegates to be credited in attendance. The Chairman of the Credentials Committee is required to report to the House the number of delegates registered, thus eliminating the necessity of a roll call to seat delegates.

Our deliberations in the House of Delegates, as well as the Board of Governors and all Councils and Committees, are governed by parliamentary usage as contained in Sturgis' Standard Code of Parliamentary Procedure. This will prevail unless otherwise provided by Florida Medical Association Charter or By-laws, or unless waived or modified by a two-thirds vote of the members present at any session of the general assembly or meeting of the House of Delegates.

Each of you as a delegate is an official of the Florida Medical Association. Collectively, you act as spokesmen and voice of the more than 14,000 FMA members. We encourage all of you to have active participation in the debate during the course of the hearings which are so important and vital to our Association. The participation requires a significant amount of time, but the personal satisfaction of carrying out this responsibility, the representation of your friends and colleagues, makes it well worthwhile. This year the Reference Committees are expanded to seven members including the Chairman. All may participate in deliberations and be seated on the podium during the committee representation. Only five may vote. The reason for seven is that we need more people intimately involved in decisions of the import entrusted to these committees. The additional input is beneficial and the training and exposure the individuals who are picked receive enables them to at a later time become more intimately associated with the affairs of the organization and the necessity for evaluating pros and cons of various issues.

At some time or another there are also obvious and necessary absences and the increased number of members tends to avoid as much as possible personal stress on the committee.

It is likely that items of interest in a different reference committee could cause a time conflict. Inasmuch as possible, this will be worked out on an individual basis by contacting the Chairman of the respective reference committees. Each reference committee has a senior staff person as well as recording secretary and an AMA delegate to monitor, to give advice, or to provide technical information. Council chairmen are to be responsive to the needs of the section of the reference committee discussing their actions and activities over the year and be prepared to complement the discussions and give applicable information to the committee members as well as other people attending the hearing. This information is vital to them and it helps all concerned to be better informed and have a more pertinent discussion.

After the hearings are concluded the reference committees will go into executive sessions to prepare their reports. The reports of the reference committees will be presented in final written form to the staff for duplication by Friday at noon. There will be a limited number of copies of these reports available to each county medical society delegation by mid-afternoon on Friday.

In an effort to clarify the double negative, the Speaker would like to suggest that in the event a reference committee does not recommend the approval of an item; the report should read "disapproval." In this case, when the original item is before the House the Reference Committee recommends that you vote "no".

An innovation requested by many of the county delegations in the past was well implemented and effective last year. This will be carried out and enable a member from a delegation with the Speaker or Vice-Speaker on Friday morning to go over first drafts of reference committee reports.

By Saturday morning all of the reports will be available to all delegates and these will be taken up during the second and third meetings of the House.

It is hoped that the detailed discussions will take place in the reference committee hearings. We know that every delegate has the opportunity and privilege of discussing any item at the time that the reference committee makes its recommendations to this House. We do not want to inhibit discussion but the necessity of concise and pertinent remarks is preferred and the basic philosophy must always be majority rule; but minority will always have the opportunity to be heard.

I should like to encourage all 14,000 members of the Association to participate actively in the reference committee hearings. Obviously this is not possible, but we do need a consensus and useful dialogue should be carried out so that committees can come forth with a loud clear common voice; the opinion of the majority and this should be so stated.

Hopefully, you will all enjoy yourself and with God's blessing we will succeed in having a successful meeting beneficial to everyone.

The remarks of the Speaker of the House of Delegates were referred to Reference Committee No. III for consideration.

Vernon B. Astler, M.D., Chairman of the Board, Florida Physicians' Insurance Reciprocal, was introduced and presented the activities of the Reciprocal

Presentation of Vernon B. Astler, M.D. Chairman of the Board Florida Physician's Insurance Reciprocal

Gentlemen:

This report is presented as we approach the mid-portion of our seventh year of operations. You have in your delegate's packets the Annual Report of the Reciprocal for 1981. In this report we have attempted to clearly outline how your Reciprocal operates; the current financial status, and a history of the Company. Today, I would like to cover a few points which highlight our activities.

The Reciprocal is and has been from its original concept, free standing in the private sector and totally independent for its basic coverage, its reinsurance, and excess coverage. In view of the current and projected assessments to certain other plans and to participants in the State operated Florida Patient's Compensation Fund, this concept has proven to be very prudent.

At the end of the year the Reciprocal insured approximately 6,700 physicians for a total insurance in force of \$5.75 billion.

In 1981 our total premium income for insurance was approximately \$32.5 million for which we paid approximately \$15 million for reinsurance; that is, for the excess over our retention of \$250,000 for coverage. We are required to reserve just over \$1 million for

extended coverage (tail coverage) for those physicians who are eligible for free coverage from death, disability or normal retirement, which left the company with approximately \$16.7 million for losses and expenses for basic coverage.

Claim losses during 1981 were \$22.5 million which left the company with an underwriting loss of approximately \$8 million. Fortunately, we had an investment income of \$7.9 million which left the Reciprocal with (\$112,000) net loss.

In the early years of the Reciprocal, we were able to pay two dividends but as the claims have matured, we have found it necessary to raise the premiums 26% in 1981 and approximately 30% in 1982. The size and frequency of claims continue to escalate.

Slides • Three (3) slides display the experience of the FMA sponsored Professional Liability Insurance Program in Florida since 1963. Many of you have seen these slides previously at the Medical Malpractice Seminars which have been conducted by PIMCO.

Slide No. 1 shows the increased frequency in malpractice claims since 1963. Note the alarming rate of claims per 100 physicians which has increased from one in twenty to one in five; which translated means that one in five of us can expect to be a defendant in a medical malpractice claim in the next twelve months.

Slide No. 2 shows the ever increasing average cost per claim. The break in the graph delineates the beginning of our physician-owned company. The dotted line at the end of the graph shows the actuary's prediction which was used to calculate the premiums for 1982. One can tell at a glance that the average cost to settle a claim for policy year 1981 is predicted to be \$27,000 and \$32,000 for 1982.

Slide No. 3 shows the claims paid and reserved in excess of \$100,000. Here again, the dotted line represents the actuary's predictions. Note that prior to 1969 there were no malpractice claims for this amount. There are currently 156 claims in this category which have come from 19 different specialty groups and represents about two percent of all the claims which we have received and account for one-half of our total loss reserves.

The serious problem the Company is currently facing is the severe escalation of the cost of claims from previous years and the demands upon the company to pay additional retro insurance for these claims. Fortunately, we were able to obtain a three-year treaty with Lloyd's of London and other underwriters which has helped considerably in stabilizing the Company and establishing the terms for future years.

The Reciprocal has considered the options available to it facing the serious liability trends alluded to and fiscal soundness in determining our premium structure. Obviously we can not allow claims expense to exceed our premium income and investment income for anything more than on a short-term basis or we will become insolvent. We are making every attempt to keep the Company stable.

Some of us are of the opinion that the malpractice crisis of the mid-1970's has not been solved at all. Your Reciprocal and other physician-owned companies have merely resolved the problem of availability of Professional Liability Insurance but the escalation of costs has not been relieved and is becoming even more critical.

Your Reciprocal is most appreciative of the Special Committee appointed by the FMA Board of Governors and providing an in-depth study of the professional liability problem in Florida. A copy of this report, approved by the Board of Governors last October is included in your Delegate's packet. I recommend you read this report and actively participate in the implementation of its recommendations. I am also pleased to report the FMA Board has elected to give the malpractice crisis top priority in the coming year.

Your Reciprocal Board has been extremely active again this past year; each member of the Board contributing tremendously to our activities. We are making an attempt to review the other plans in the country and to initiate favorable options where possible. A great emphasis will be placed in the future upon medical peer consultants to each physician in the defense of their suits.

I wish to thank each of you who has assisted the Reciprocal in its many activities as consultants for underwriting, defense of claims, expert witnesses, and have shown confidence in the FMA sponsored and supported Reciprocal by participating as an insured subscriber.

W. Harold Parham, D.H.A., Executive Vice President, presented answers to the 10 most frequently-asked questions pertaining to the Reciprocal.

**Remarks — W. Harold Parham, D.H.A.
Executive Vice President**

There are 10 questions that are frequently asked about the Reciprocal and I will attempt to briefly outline and answer them. I apologize to those of you who heard this presentation at the morning session.

First, the question is, "What is a reciprocal and why did we choose a reciprocal?" When we originally organized the FMA Professional Liability Trust in 1975, to make liability insurance available to the membership it was assessable, so we terminated the Trust at the end of the first year. We had accumulated funds for surplus to form a company. We reviewed the statutes and there was a law that had not been used for many years, a reciprocal law on the books. The only difference between a reciprocal and mutual company is: mutual company members must elect a board and reciprocal subscribers do not. They incorporated me as Executive Vice President of the Florida Medical Association as an Attorney-in-Fact to act as an agent on behalf of you. In that way, it gave us the stability we needed to have stable Board membership. A mutual company must elect a Board within three years, the membership must. We could not get any reinsurance in the United States when we started our company—we had to go to the Lloyds for it, and the Lloyds and other underwriters insisted upon our having a stable Board. So that's the reason we chose the Reciprocal and why it's a reciprocal rather than a mutual company.

The remark was made not too long ago that the Association and Board lost control of the Reciprocal as it did Blue Shield a number of years ago. Let me assure you of this, that first of all, I serve at the pleasure of the Board of the Reciprocal, that they may remove me with 60 days notice for no reason whatsoever if they wish to do so. All policies of the Reciprocal, including investments, rates, premiums, in fact every action I take on behalf of the Reciprocal must be approved by the Reciprocal Board. This is done at their meetings every other month, whatever the transaction might be. I think all of you are familiar with the reports you have, who the Reciprocal Board is composed of; five Past Presidents of this organization. The question came up, "Well, what did you do, set up a retirement program for Past Presidents of the FMA?" and the answer to that is NO. These men gave of their time and energies for years and only last year was any compensation ever made to the Reciprocal Board members. They have a claims conference every other Tuesday afternoon, it is a lengthy conference by telephone, hours are spent in preparation of these claims, in reviewing before they have the meeting. They are a very, very active group. The Reciprocal Board members are paid \$500 a month as medical consultants for review work, underwriting and claims and \$500 a month as corporate directors of the Reciprocal. The time and energy they expend would be a bargain at many times that amount.

The next question that comes up is, "What are your responsibilities as the Attorney-in-Fact?" First of all, as I mentioned to you, I am a corporate entity responsible for all contracts that are entered into by the Reciprocal, i.e., a contract with PIMCO to manage underwriting and claims, etc. I'm



W. Harold Parham, D.H.A.

directly responsible for all accounts, reports to the Insurance Commissioner and matters of that nature. We have three full-time CPA's on the staff that are directly responsible to me for financial accountability. They are employees of PIMCO but are assigned to me for the work to be done. From the investment standpoint, we have an officer of Oppenheimer who advises us on the investments, we have a full-time portfolio manager within the office responsible to me but again everything is done under the guidelines of the Board and the Board approves every single transaction that is made on investments.

The next question that arises is with reference to reinsurance and trips to England. The party we have in England two or three times a year—first of all, none of the Reciprocal Board members have been to England [with the exception of Dr. Astler, the Chairman] on business representing the Reciprocal. Dr. Walker as President of PIMCO and I go to London each June, present our actuarial studies, an outline of what we need and what we think our suggested rates should be for the next year. In September or October, Dr. Astler as Chairman of the Board, and I go back to England to negotiate the contract and the final rates for the succeeding year. This past year, we went to England on Monday, worked Tuesday and Wednesday, and came home on Thursday and I assure that this was no party and we negotiated a precedent-setting three year Treaty.

The next question, "Why do we have PIMCO? Why can't the Reciprocal hire their own employees?" Fortunately we were the first association in the country to own its own insurance agency. We had Harlan-Med, Inc. The FMA owned 50% of this insurance agency which we established in the early 70's. After the Argonaut Trial there was no longer any need for an insurance agency any more but Harlan-Med had all the contracts, all the applications, all the records, furniture, people and everything to go into business. So plain and simple, we just terminated our contract with Harlan of Texas, by the way, they had 520 agency affiliates, they were one of the largest systems in the country. We took these assets and formed PIMCO and we were immediately ready to go to work with our records, applications and everything else from the previous company. Another major function that PIMCO has [that Harlan-Med also had] it is the manager or the insurance agency for the other FMA insurance program, the disability, life insurance and policies of that nature. We think we have a very efficient operation in PIMCO with a very low operating overhead.

The next question comes up, "Who's the PIMCO Board and how are they ripping us off?" First of all, Jerome Fletcher was Chairman of the Board of Harlan of Texas and was responsible for Harlan joining FMA in establishing Harlan-Med. He agreed to come on the Board to help us continue what was the Harlan-Med operation. Jerome's serving on the Board has been a tremendous help to us. Bruce Woolery who was the President of Argonaut

when we negotiated the Argonaut contract and with them 24 years, after the Federal trial in Florida, New York and elsewhere, 11 of the 13 executives of the Argonaut resigned because they had been dishonored by Teledyne. Mr. Woolery came in, spent the spring of 1975 with me in a Federal Court in Jacksonville as our witness in that trial and since that time, except when he had a recent heart attack, he has been to Jacksonville almost every other month with a few exceptions for five or six years to assist us in this program.

"Why is Mr. Edgar Cowart on the PIMCO Board, he's an investor?" Well, first of all, he's the one who volunteered a million dollar letter of credit for us to start the company and no one else was quite so generous. He's been a tremendous asset to us from the standpoint of investments and management. The other Directors are outlined in the Annual Report.

The PIMCO Board is compensated in a similar manner as the Reciprocal Board, they are paid \$500 a month as Directors' fees. PIMCO is a stock company, the Reciprocal owns half of the PIMCO stock (the Florida Medical Association sold it to the Reciprocal three or four years ago to avoid any Federal trade regulation problems). The other half is owned by the Directors. They receive approximately \$6,000 a year each in dividends. They have roughly \$1,000 a month income with one exception. Mr. Woolery does a study for us every month called the Woolery Report on the patterns and trends of our losses. You have to look at what's going on today and yesterday to have some idea what's going to happen tomorrow. We pay Mr. Woolery an additional \$1,000 a month as consultant fees and I guarantee you he earns every bit of it, you couldn't hire him for this. He is one of the top insurance executives in the country.

Now the question "Why do you have to continue with the Lloyds?" When you have a claims-made policy, it is almost impossible to get rid of your reinsurance carrier or to change your reinsurance or to change the form of insurance because of the liability you have for previous years. It is almost impossible to make any changes. When we purchase our reinsurance with the Lloyds and other underwriters we only make a premium deposit. For this particular year it is 17% of our premium. If 1982 goes sour, we'll have to pay 42½% of our premium in retro; there's a potential liability of over 10 additional million dollars for this year. There are 27 underwriters at Lloyds that are on our treaty, three of them take the main lead and research our programs in depth.

The next question that comes up, "What are you doing operating an insurance company in the Islands?" Let me explain that, rebates of commissions are illegal in most states if not all in the United States. To do business with a reinsurer at the Lloyds you have a broker in the states. We have the Wetzel Company of Houston which is one of the finest reinsurance brokerage firms in the country. They are primarily involved in the oil industry-ships, tankers, gas lines, etc. We discussed this with Mr. Wetzel and what we did, we set up a company called Caribe-Re in Grand Cayman, British West Indies. We looked at Nassau, we looked at Bermuda, and this was the most stable place as a British Crown Colony to establish it. You might be interested that many of your major companies have reinsurance facilities off-shore. Mr. Wetzel manages the entire operation of Caribe-Re along with some other companies there, for 50% of the commission. We take the other 50% of the commission at the end of the year and declare a dividend so that we get 25% of the commission back. This amounted to \$87,000 in 1981 and our cost for the whole operation was less than \$3,000 so I think it is a fairly handsome return.

The next question that comes up frequently, "Well, why are you investing in real estate and what the hell do you know about it?" At a time that you have high interest rates and shortage of construction financing money there's some outstanding opportunities to be made with the appropriate people in the real estate area. The Reciprocal Board authorized a small percentage of its assets to be invested in real estate and last year added more

and is now about nine percent of our total assets. We have joined as a limited partner with some very substantial people. There was an apartment house in Jacksonville, Broadview Terrace, that was built by A.D. Davis, the Chairman of the Board of Winn-Dixie, about 18 years ago and one of our more prominent financial people in Jacksonville said would you like to join us on this and convert it to condominiums and I'll guarantee your money. He had just negotiated the lease money on a shopping center for approximately \$75,000,000 so he wasn't particularly short of cash. One year ago we went into this venture with a quarter-of-a-million dollars, 31 of the 48 units were sold to people who lived there for cash. We are wrapping it up now, approximately a year later, we got our quarter-of-a-million dollars back, a quarter-of-a-million in profits with additional potential. I think that is a rather good return on our money. Over 100% interest annualized. Two other projects we're going into this year are very exciting. One of them is a Planned Urban Development. The Reciprocal puts the money up, and we have a guarantee by the holding company that any time we want to get out of it we will be paid 20% interest annualized. However, if we stay until April of next year, we get our \$3,000,000 back plus 3.5% interest. The next year we get 62% interest. The next year, 77% - 37.7% next year and 15.6% the last year, a great return with a guarantee from a major corporation that we can't lose. I think that's pretty good odds.

The next question I'm asked, "What're you doing with an airplane?" Well let me tell you about the airplane just very briefly. We got a good buy on it first of all. Jack Eckerd bought the plane for his governor's race in 1978. When the race was over with the press corp had torn up the seats in it. So all we had to do was reupholster the plane. A real good investment credit and depreciation. There are several reasons why we've kept it and not sold it even when we've been subject to some criticism for it. First of all we have over 1,000 cases in the courts of this state today. We have over 80 attorneys retained to defend these cases, there's a tremendous amount of travel involved. We also lease the plane to the Florida Medical Association when it's needed. PIMCO uses the plane primarily for risk management conferences, the Reciprocal Board uses it occasionally (not too often) when we have a one-day meeting. Sometimes we pick up the people on the way to Tampa and drop them off on the way back home. We also have a mechanical contractor that uses the plane and guarantees us so many hours a year. The plane's not that expensive when you consider the convenience and savings on time, meals and hotel rent. When you take a look at what it is being used for and the efficiency of it, I think we can justify with anybody who would like to take a look at it. Now to my knowledge this plane has never been used for any personal reason, even whether they paid for it or not. Dr. Thames is a member of the Reciprocal Board who annually audits every invoice and payment that I, as Attorney-in-Fact, have on behalf of the Reciprocal. Dr. Thames has audited the log on the plane and he can certainly assure you that the hour meter checks and the plane has not been abused or used improperly.

The next question I'm asked "Well how about that rip-off Harold? Can you lend me \$100,000?" I was loaned to the Trust and the Reciprocal when we started because I was free to them. The FMA had me and they said just go over set up this company and do this job because they didn't have the money, so that's what we did. That was seven years ago and I'm still there and since I have been there I've been paid \$1 a day for my services as Attorney-in-Fact and President of the Reciprocal. I serve as Chairman of the Board of PIMCO voting the Reciprocal stock to monitor and audit the contract we have with PIMCO for claims, underwriting, and all the business that it conducts on behalf of the Reciprocal. For that position, I was paid \$1 a day until December 31, 1981. The Reciprocal Board, the PIMCO Board and the FMA Board of Governors agreed to reduce my compensation by 50% at FMA because I was spending more time with the Reciprocal than I was spending with the FMA. Most of you are aware that I'll be leaving the FMA entirely in the next couple of

years as far as an active role in management of the organization after 35 years. Mr. Jones was designated the Chief Executive Officer in January of this year, so I have moved more into an advisory capacity. As Chairman of the Board of PIMCO, I receive a consultant fee on an annual basis to make up for the loss that I had from the FMA. This is reimbursed by the Reciprocal.

I only have two other comments to make, a little look at the future. Great time and effort has been put into our Tort reforms, untold thousands of dollars, people, the Auxiliary, everybody involved has really worked for years now and from where I stand we still have a serious problem. The Judiciary is paying little attention to these laws. The Judiciary does not apply the law regarding remittitur-additur, structural settlements, etc. We have to take it to appeal and it just burns up money and time. We're going to have to have a major change in our social system and let me give you two examples. First of all, these jumbo awards did not start in the malpractice area. The first one as I recall was when the plane missed the runway in Miami and killed some children and it was a million dollar award for each of those children to the families of those children, and in second instance, it was in the late 50's or early 60's, when the Chairman of the Board of a major corporation ran over a child and killed it in Miami, this resulted in a million dollar award. Something happened to us just this past year that displays how ridiculous our Judicial system operated. I don't want to change the system, but how it is applied at times is ridiculous. A Haitian woman on a work permit in a migrant camp in Palm Beach County delivered a child and a physician was involved with the delivery at the camp. There was some brain damage or retardation because of the blood chemistry of the child. If it had been in Jacksonville Memorial's Neo-natal unit it would have been a different story, but our medical consultants were of the opinion there's no negligence in this case. The child's now four years of age. Our investigators could not determine any variation with the other Haitian kids his age. The jury awarded \$1,800,000 which made this child the richest individual in the country and probably ten times richer than anybody else there. We have it on appeal at the present time but we're required to put up \$1,800,000 in bond, also \$500,000 for attorneys fees to appeal it.

Now the whole area of liability is a little bit frightening to me. Last month, I don't know when the accident was, but the decision was made last month, in Arkansas. Two 18-wheelers were on a two-lane road, one passing the other one and they hit a car. A mother was killed, one of the children was killed, the father was incapacitated and the other child survived. It was an out-of-court settlement of \$27,000,000. Now that wasn't even a jury award, that was an out-of-court settlement to avoid paying more.

Sometime we are going to have to figure out what a human life is worth under our Tort system. I don't see how our current economy and our current system (particularly the medical profession) can carry the load for life insurance, disability insurance and many others for which nobody has ever paid a premium.

Thank you very much.

Dr. Sanford A. Mullen, President, assumed the Chair to present the A.H. Robins Company Award for Outstanding Community Service by a Physician. Dr. Mullen introduced Mr. Gerald W. Kerlin, a representative of the A.H. Robins Company, and announced that V.A. Marks, M.D. of North Palm Beach, Florida was the recipient of the Award. Dr. Mullen requested that Drs. Luis Guerrero and Dick L. Van Eldik of Palm Beach County escort Dr. Marks to the podium to receive the award.

A.H. Robins Company Award For Outstanding Community Service By A Physician

Whereas, V. A. Marks, M.D., of North Palm Beach, Florida, has established himself both as a leader in organized medicine and his community; and

Whereas, He currently serves as mayor of North Palm Beach and as President of the Palm Beach County Medical Society while fulfilling the duties as Chief of Staff of the Palm Beach Gardens Community Hospital; and

Whereas, Dr. Marks served as a delegate to the Michigan Medical Association from 1959 to 1971 and has been a delegate to the Florida Medical Association since 1977; and

Whereas, He is a Fellow of the American College of Obstetrics and Gynecology and Diplomate of the American Board of Obstetrics and Gynecology; and

Whereas, He was fund-raising chairman for the Midland Economic Development Corporation in 1968 and participated in the political process as finance chairman in 1978 and 1980 for State Senator Tom Lewis; and

Whereas, This native of Hopewell, Va., continues daily to bring honor to himself, his community, his peers and the ranks of organized medicine; therefore be it

RESOLVED, That the Board of Governors, the members and staff of the Florida Medical Association convey to V. A. Marks, M.D., sincere best wishes and appreciation as recipient of the A. H. Robins Company Award for Outstanding Community Service by a Physician.



At the first session of the House of Delegates, V.A. Marks, M.D., of North Palm Beach, was announced as the winner of the A.H. Robins Company Award for Outstanding Community Service by a Physician. Here, he and Mrs. Marks display the award for The Journal's photographer.



FMA Past Presidents had their traditional breakfast meeting during the Annual Meeting, after which they posed for their customary group picture. First row (left to right): Samuel M. Day, M.D. (1964); Henry J. Babers, M.D. (1969); Jere W. Annis, M.D. (1958); H. Phillip Hampton, M.D. (1965); George S. Palmer, M.D. (1966); and Jack Q. Cleveland, M.D. (1968). Second row: Jack A. MacCris, M.D. (1976); James T. Cook Jr., M.D. (1970); O. William Davenport, M.D. (1978); Thomas B. Thames, M.D. (1980); William J. Dean, M.D. (1972); and Louis C. Murray, M.D. (1977).

Dr. McKechnie, Vice-Speaker, introduced Mrs. Frank Coleman, President of the Florida Medical Association Auxiliary. Mrs. Coleman expressed the thanks of the Auxiliary to members of the Association for their support during the past year, and outlined some areas of Auxiliary service to the Association. These were:

- Involvement in worthwhile community service projects
- Fund Raising
- Volunteer work with legislative program endorsed by the FMA

Mrs. Coleman pointed out that the Florida Auxiliary is the third largest State Auxiliary in the nation, and expects to overtake the second place state.

Dr. McKechnie then introduced Mrs. Daniel B. Nunn, President-Elect of the FMA Auxiliary; Edward R. Annis, M.D., Past President of AMA; James W. Walker, M.D., Past Officer of FMA and President, PIMCO; Mrs. Linus W. Hewit, AMA Auxiliary Board member; Mrs. B. David Epstein, Past President of the FMA Auxiliary and a member of the AMA Auxiliary Board; and Frank Holland, M.D., Past Vice President of AMA.

Dr. Perry introduced the President, Dr. Sanford A. Mullen. Dr. Mullen addressed the House (a text of Dr. Mullen's remarks appears elsewhere in this issue of *The Journal*).

Dr. Perry announced corrections to the Handbook:

1. Page 11, at top of page, "Dade (cont'd)" should read "Duval (cont'd)".
2. Page 20, near the bottom of the page, "Election of Judicial Council member...", should read "from Medical District D", rather than *Congressional District*.

Dr. Perry announced the members of the Reference Committees, the assignment of AMA Delegates to the Reference Committees and the times that each Reference Committee would meet.

Reference Committee No. 1 Health and Education

C. Fenner McConnell, M.D., Chairman (AL)
(Escambia)
James T. Cook III, M.D. (A) (Bay)
Joseph F. Sullivan, M.D. (B) (Collier)
Elizabeth J. Barice, M.D. (C) (Palm Beach)
Richard C. Clay, M.D. (D) (Dade)
Donald L. Ames, M.D. (C) (Indian River) (Alt.)
Stanley S. Goodman, M.D. (C) (Broward) (Alt.)
AMA Delegate Advisor: Richard G. Connar, M.D.
(Alternate — Charles J. Kahn, M.D.)

Reference Committee II Public Policy

Robert H. Hux, M.D., Chairman (AL) (Lake)
 John F. Lovejoy Jr., M.D. (A) (Duval)
 Thomas R. Busard, M.D. (B) (Manatee)
 Jerry D. Moore, M.D. (C) (Broward)
 Charles A. Dunn, M.D. (D) (Dade)
 John M. Canakaris, M.D. (A) (Flagler) (Alt.)
 Paul J. Popovich, M.D. (C) (Brevard) (Alt.)
 AMA Delegate Advisor: Samuel M. Day, M.D.
 (Alternate — Vincent P. Corso, M.D.)

Reference Committee No. III Finance and Administration

William C. Hartley, M.D., Chairman (AL) (Broward)
 Robert H. Threlkel, M.D. (A) (Duval)
 Kay K. Hanley, M.D. (B) (Pinellas)
 Alvin E. Smith, M.D. (C) (Volusia)
 Margaret C.S. Skinner, M.D. (D) (Dade)
 Ronald W. Case, M.D., (B) (Polk) (Alt.)
 David R. Arrowsmith, M.D. (A) (Okaloosa) (Alt.)
 AMA Delegate Advisor: Rufus K. Broadway,
 M.D. (Alternate — Vernon B. Astler, M.D.)

Reference Committee No. IV Legislation and Miscellaneous

Edward Ackerman, M.D., Chairman (AL) (Orange)
 Faris S. Monsour, M.D. (A) (Duval)
 Kenneth C. Kiehl, M.D. (B) (Sarasota)
 Hector R. Mendez, M.D. (C) (Orange)
 Robert E. Boyett, M.D. (D) (Dade)
 Juan S.A. Wester, M.D. (C) (Broward) (Alt.)
 James E. Carter, M.D. (C) (Brevard) (Alt.)
 AMA Delegate Advisor: Joseph C. Von Thron,
 M.D. (Alternate — Francis C. Coleman, M.D.)

Reference Committee No. V Medical Economics

Franklin H. Pfeiffenberger, M.D., Chairman (AL) (Sarasota)
 Barney E. McRae, M.D. (A) (Columbia)
 Calvin W. Martin, M.D. (B) (DeSoto-Hardee-Glades)
 Fred S. Carter, M.D. (C) (Martin)
 Richard D. Miller, M.D. (D) (Dade)
 Ronald L. Seeley, M.D. (B) (Hillsborough)
 (Alternate)
 Peter A. Tomasello, M.D. (C) (Broward) (Alt.)
 AMA Delegate Advisor: T. Byron Thames, M.D.
 (Alternate — Eugene G. Peek Jr., M.D.)



Dr. and Mrs. Sanford A. Mullen at the President's reception.

Dr. Perry announced that the assignments of reports and resolutions to Reference Committees were as indicated in the Handbook.

The Vice Speaker announced the assignment of Supplemental Reports and Resolutions which were received too late for inclusion in the Handbook and which had been inserted into the Delegates' packets as indicated on the reports.

The Speaker called for any reports which had been received too late to be included on the agenda. Board of Governors Report F was submitted, and there being no objection, it was placed on the agenda.

Dr. Perry announced the dates and times of the Blue Shield Informational Meeting, the Baldwin Lecture, the Florida Physicians Association Annual Membership Meeting, the President's Reception and the FLAMPAC/Auxiliary Luncheon.

The House recessed at 5:30 p.m. to reconvene on Saturday, May 8, at 3:00 p.m.



Annual meeting highlights

(1) Guy T. Selander, M.D., of Jacksonville (left), escorts Yank D. Coble Jr., M.D., also of Jacksonville, to the head table to assume his new office as Treasurer of the FMA. (2) Members of the Palm Beach County Medical Society escort V.A. Marks, M.D., to head table to receive the Robins Award. (3) Medical student Harvey Robles of Miami (left) was first across the finish line this year in the Annual Health Run. C. Fenner McConnell, M.D., of Pensacola (right), the winner the past two years, finished second to Mr. Robles. (4) Edward R. Annis, M.D., of Miami (right) emphasizes a point in conversation with Baldwin Lecturer John W. Mazzola of New York City (left) and FMA President Sanford A. Mullen, M.D. (5) For the second year in a row, Robert S. Brittain, M.D., of Denver, Colo., presented a Seminar on Medical Malpractice Prevention at the Annual Meeting. (6) The transition of the FMA presidency from Sanford A. Mullen, M.D., of Jacksonville

(left) to Robert E. Windom, M.D., of Sarasota, is consummated with a warm handshake and a friendly smile on the part of both. (7) Mr. and Mrs. Davis S. Whittaker of Ocala were judged the winners of a jitterbug contest that was an event of the President's Tea Dance. (8) President-Elect Robert E. Windom, M.D., visited with U.S. Sen. Paula Hawkins of Florida before Senator Hawkin's address at the Annual Auxiliary - FLAMPAC Luncheon. (9) Dr. Windom addresses the House of Delegates. (10) Among guests at the Annual Editor's Dinner were Mrs. Daniel B. Nunn, of Jacksonville (left), Student Consulting Editor James Deming, and Mr. Deming's date. (11) Newly-elected FMA Vice President James F. Richards Jr., M.D., of Orlando, is welcomed into the FMA leadership by President-Elect Robert E. Windom, M.D. (12) FMA Past President T. Byron Thames, M.D., of Orlando, JFMA Editor Daniel B. Nunn, M.D., of Jacksonville, and Dr. Nunn's daughter, Myra.



General Session

The General Session of the 108th Annual Meeting of the Florida Medical Association was called to order at 11:00 a.m. on Friday, May 7, 1982, in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, by the President, Sanford A. Mullen, M.D.

Dr. Mullen introduced the officers seated at the head table and then announced the winners of the 1982 Scientific Exhibit Awards.

1982 Scientific Exhibit Awards

First Place

"Pitfalls in the Diagnosis and Treatment of Severe Pit Viper Envenomation"

William J. Bailey, M.D. and Thomas R. Sprenger, M.D., Naples, Florida.

Second Place

"A Prosthesis for Palliative Treatment of Carcinoma of Hepatic Bile Duct"

Paul H. Niloff, M.D. and Fred L. Simon, M.D., Lake Worth, Florida.

Third Place

"Pulsed Doppler Imaging for Patients with Ophthalmic Disorders"

William M. Blackshear, M.D., W. Sanderson Grizzard, M.D. and James A. Rush, M.D., Department of Ophthalmology, University of South Florida College of Medicine, Tampa, Florida.



Eugene G. Peek Jr., M.D. (standing left), President of the Florida Medical Foundation, presented AMA-ERF checks to Florida's three medical schools. Accepting the checks were (second from left to right): William A. Sodeman Jr., M.D., University of South Florida; Jonathan Braunstein, M.D., University of Miami; and William B. Deal, M.D., Dean, University of Florida College of Medicine. Others in picture: Mrs. Frank C. Coleman, President of the FMA Auxiliary; Mrs. Priscilla Gerber, Auxiliary AMA-ERF Chairman (at microphone); and FMA Executive Vice President W. Harold Parham, D.H.A.

Honorable Mention

"Craniofacial Surgery: The State of the Art at the Tampa Bay Craniofacial Center"

Mutaz B. Habal, M.D. and Jack E. Maniscalco, M.D., Tampa Bay Craniofacial Center and University Community Hospital, Tampa, Florida.

"Hemodynamics, Atrial Dysrhythmia, Pathology and Surgical Treatment of Mitral Valve Disease"

R. Vijayanagar, M.D., D. Bognolo, M.D., P. Eckstein, M.D., D. Jeffrey, M.D., S. Sbar, M.D., P. Natarajan, M.D. and E. Willard, M.D., Tampa, Florida.

"Foreign Bodies in Pediatric Tracheobronchial Tree"

Farhat Moazam, M.D., Frederick C. Ryckman, M.D., John W. Robertson, M.D. and James L. Talbert, M.D., University of Florida College of Medicine, Gainesville, Florida.

Although there is no appropriate award ribbon, the judges voted special recognition to an exhibit entitled "Public Health Epidemiology and Community Involvement" sponsored by Ramona M. Medina, R.N. and Robert May, M.D., of the Pasco County Health Department, New Port Richey. Dr. May and his county health department have been bringing an exhibit to this meeting for the past few years.

Dr. Mullen invited Dr. Eugene G. Peek Jr., President of the Florida Medical Foundation and Mrs. Frank C. Coleman, President of the FMA Auxiliary, to come to the podium for the presentation of grants from the AMA-ERF to medical school deans. Mrs. Coleman introduced Mrs. Priscilla Gerber, Chairman, AMA-Educational Research Fund.

Dr. Peek made the following presentations: \$6,245.75 to Dr. William A. Sodeman Jr., accepting for Dr. Andor Szentivanyi, Dean, University of South Florida College of Medicine, Tampa; \$8,080.85 to Dr. Jonathan Braunstein, Associate Dean of Medical Education, University of Miami School of Medicine, Miami; \$10,000.00 to Dr. William B. Deal, Dean, University of Florida College of Medicine, Gainesville; and \$2,000.00 for the Program in Medical Sciences, Florida State University, which was accepted by Dr. William B. Deal.

After the presentations, Mrs. Coleman made a special presentation to Dr. Peek of a check for \$4,000 for the Impaired Physician Program of the Florida Medical Foundation.

Dr. Windom introduced Dr. Pablo Enriquez of Melbourne, who announced that the Florida Society of Pathology has established an annual award to an outstanding pathologist in Florida and that the award has been named in honor of Sanford A. Mullen, M.D. Dr. Mullen then presented the Sanford A. Mullen, M.D., Florida Society of Pathology Annual Award to C. Fenner McConnell, M.D. of Pensacola, who has not

only been outstanding in his profession but has also been involved heavily in organized medicine. Dr. McConnell was also cited for his contributions to the educational, social and civic affairs in his community.

The President then called Dr. Daniel B. Nunn, Editor of *The Journal of the Florida Medical Association*, to the platform to assist in presenting the awards for the Fifth Annual JFMA Awards Contest for County Medical Society Bulletins.

Winners of Fifth Annual JFMA Awards Contest for County Medical Society Bulletins

Category I: General Excellence

The Stethoscope (Bulletin of the Volusia County Medical Society), R. C. Lacsamana, M.D., Editor

Category II: Most Improved Bulletin

The Bulletin of the Hillsborough County Medical Association, Louis E. Cimino, M.D., Editor.

Category III: Best Editorial

First Place: *The Bulletin of the Marion County Medical Society*, Winning Entry: "Why Bother with Politics?" (March 1981), Henry L. Harrell Jr., M.D., Editor.

Honorable Mention: *The Lee County Medical Society Bulletin*, Cited Entry: President's Message, "The Complete Physician" by Stephen Zellner, M.D. (February 1981), Thomas M. Wiley Jr., M.D., Editor.

Category IV: Best Regular Feature

First Place: *Miami Medicine* (Bulletin of the Dade County Medical Association), Winning Entry: "President's Report" by Robert Boyett, M.D., Richard J. Feinstein, M.D., Editor.

Honorable Mention: *Jacksonville Medicine* (Bulletin of the Duval County Medical Society), Cited Entry: "President's Page" by Faris S. Monsour Jr., M.D., Frederick W. Schert, M.D., Editor.

Category V: Special Recognition

Polk County Medical Association Bulletin, for serving a variety of physician interests, John W. Glotfelty, M.D., Editor;

The Escambia County Medical Society Bulletin, for complete coverage of medical activities in Escambia County, F. Norman Vickers, M.D., Editor.

Dr. Mullen introduced Mr. John W. Mazzola, President of Lincoln Center for the Performing Arts in New York City. Lincoln Center owns, among others, the New York City Ballet, the Metropolitan Opera, Lincoln Center for the Performing Arts and the Julliard School of Music. The community and programming activities of Lincoln Center have expanded greatly over the years to include Lincoln Center Out-of-Doors, *Live from Lincoln Center*, the Mostly Mozart series, and many others.

Mr. Mazzola explained that these community activities are not only beneficial on a cultural level but also economically: creating jobs in construction and expanded facilities' staffing, local restaurant



C. Fenner McConnell, M.D., of Pensacola (center) was named the recipient of the first Sanford A. Mullen, M.D., Florida Society of Pathologists Annual Award, named in honor of FMA's outgoing President (left). Making the presentation is Pablo Enriquez, M.D., of Melbourne, President of the Society.

business, local transportation services and many, many more. Mr. Mazzola estimated that approximately \$350-450 million is returned to the local economy through the various components of Lincoln Center.

Although a large populated area, such as New York, can carry the expanded activities of a performing arts center, Mr. Mazzola spoke of the increasing numbers of centers for the performing arts throughout the country and their role in helping to build up a community. Small communities as well as major cities are developing and promoting this concept which Mr. Mazzola smilingly referred to as the "edifice complex".

Dr. Mullen adjourned the General Session at 12:00 noon.



Mr. John W. Mazzola of New York City, President of the Lincoln Center for the Performing Arts, presented the annual Abel S. Baldwin Lecture on Friday of the Annual Meeting.

Eight county bulletins honored

Eight county medical society bulletins received plaques in the Fifth Annual Journal of the Florida Medical Association Awards Contest for County Medical Society Bulletins. FMA President Sanford A. Mullen, M.D., and JFMA Editor Daniel B. Nunn, M.D., presented the awards at the General Session on Friday. (1) R.G. Lacsamana, M.D., Editor of The Stethoscope (Volusia County) accepts the General Excellence Award, the top prize. (2) Louis E. Cimino, M.D., Hillsborough CMA's Editor, accepts the Most Improved Bulletin award. (3) Editors F. Norman Vickers, M.D., of Escambia County, and John W. Glotfelty, M.D., of Polk County, tied for First Place in the Special Recognition Category. (4) Miami Medicine's first place award for Best Regular Feature was accepted by Editor Richard J. Feinstein, M.D. (5) Henry L. Harrell Jr., M.D., accepts the Best Editorial Award for his Marion County Bulletin, while (6) Stephen R. Zellner, M.D., accepts Honorable Mention in that category for Lee County. (7) William P. Booras, M.D., and Faris S. Monsour, M.D., accepted an Honorable Mention in Best Regular Feature for Jacksonville Medicine.



Second House of Delegates

The Second Meeting of the House of Delegates convened at 3:00 P.M., Saturday, May 8, 1982, in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, with Dr. James B. Perry, Speaker of the House, presiding.

Dr. Samuel M. Atkinson Jr., Co-Chairman of the Credentials Committee, reported that 259 delegates were present with 37 component county societies represented, constituting a quorum, and moved that the delegates be seated. The motion carried.

Delegates

ALACHUA—O. Frank Agee, M.D.; Raymond H. Alexander, M.D.; William B. Deal, M.D.; Charles P. Gibbs, M.D.; Douglas O. Jenkins, M.D. (Absent—Mark V. Barrow, M.D.; Student, Diane M. Zabak.)

BAY—James T. Cook III, M.D.; Terrence R. Steiner, M.D.

BREVARD—James E. Carter, M.D.; Walter A. Cerrato, M.D.; Michael J. Foley, M.D.; Francis S. Pooser, M.D.; Paul J. Popovich, M.D. (Absent—Ovidio E. Vitas, M.D.)

BROWARD—Robert L. Berger, M.D.; Anna M. Blenke, M.D.; Robert J. Brennan, M.D.; Andre S. Capi, M.D.; Phillip A. Caruso, M.D.; David A. d'Alessandro, M.D.; Authur L. Eberly, M.D.; Paul A. Flaten, M.D.; Stanley S. Goodman, M.D.; John M. Harper, M.D.; William C. Hartley, M.D.; Wilber F. Helmus, M.D.; David C. Lane, M.D.; Robert J. Lenar, M.D.; George P. Messenger, M.D.; Alexander E. Molchan, M.D.; Jerry D. Moore, M.D.; Donald J. Plevy, M.D.; Thomas F. Regan, M.D.; Joseph M. Sachs, M.D.; Ernest G. Sayfie, M.D.; Richard D. Shafron, M.D.; Herbert M. Todd, M.D.; Peter A. Tomasello, M.D.; Anthony J. Vento, M.D.; Juan S. Wester, M.D.; (Absent—Kenneth H. Farrell, M.D.; Richard D. Schultz, M.D.)

CAPITAL—Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Robert N. Webster, M.D.

CHARLOTTE—Thomas R. Civitella, M.D.; Joseph R. Goggin, M.D.; Jaime Torner, M.D.

CITRUS-HERNANDO—Wilburn R. Jenkins, M.D.; Clinton J. McGrew, M.D.

CLAY—(Absent—Hinson L. Stephens, M.D.)

COLLIER—Charles J. Montgomery, M.D.; Virgil A. Ponzoli Jr, M.D.; Joseph F. Sullivan, M.D.

COLUMBIA—Barney E. McRae, M.D.

DADE—Edward R. Annis, M.D.; Jerome Benson, M.D.; Robert E. Boyett, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; Victor O. Calderin, M.D.; Edmund Cava, M.D.; Richard C. Clay, M.D.; Vincent P. Corso, M.D.; DeWitt C. Daughtry, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Charles A. Dunn, M.D.; Augusto Fernandez-Conde, M.D.; Miguel Figueroa, M.D.; N. Ralph Frankel, M.D.; George R. Gage, M.D.; Richard L. Glatzer, M.D.; Alan S. Graubert, M.D.; Julian H. Groff, M.D.; Joseph Harris, M.D.; Walter C. Jones III, M.D.; Herbert S. Kaiser, M.D.; Norman M. Kenyon, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Roberto L. Maury, M.D.; William T. Mixson, M.D.; Charles A.

Monnin Jr., M.D.; Miguel A. Mora, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Jorge R. Pena, M.D.; Pedro A. Ramos, M.D.; William I. Roth, M.D.; Walter W. Sackett, M.D.; Daniel L. Seckinger, M.D.; Everett Shocket, M.D.; M. David Sims, M.D.; Margare C.S. Skinner, M.D.; Douglas Slavin, M.D.; Marvin B. Slotkin, M.D.; Samuel P. Stokey, M.D.; Charles F. Tate, M.D.; John C. Turner, M.D.; Thomas B. Turner, M.D.; Osvaldo D. Valdes, M.D.; Edgar W. Webb, M.D.; Harold H. Weiner, M.D.; Steven M. Weissberg, M.D.; Bruce W. Weissman, M.D.; Leo Whitman, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D.; Student, James E. Deming. (Absent—William P. Calvert, M.D.; Melvin A. Klein, M.D.)

DESOTO-HARDEE-GLADES—Calvin W. Martin, M.D.

DUVAL—Samuel J. Alford Jr, M.D.; Mohamed H. Antar, M.D.; William P. Booras, M.D.; Yank D. Coble, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; William J. Garoni Jr, M.D.; Charles P. Hayes Jr, M.D.; Benjamin A. Johnson, M.D.; Charles W. Lewis, M.D.; John F. Lovejoy Jr, M.D.; Faris S. Monsour, M.D.; Daniel B. Nunn, M.D.; Guy T. Selander, M.D.; Robert H. Threlkel, M.D.; James W. Walker, M.D.; William D. Walklett, M.D.; (Absent—Gaston J. Acosta-Rua, M.D.; Charles B. McIntosh, M.D.)

ESCAMBIA—Richard H. Ciordia, M.D.; Eric F. Geiger, M.D.; Charles J. Kahn, M.D.; Theodore J. Marshall, M.D.; Charles F. McConnell, M.D.; F. Norman Vickers, M.D.

FLAGLER—John M. Canakaris, M.D.

FRANKLIN-GULF—Joseph P. Hendrix, M.D.

HIGHLANDS—(Absent—Luis M. Pena, M.D.; Robert T. Rengarts, M.D.)

HILLSBOROUGH—Richard A. Bagby, M.D.; Frank C. Coleman, M.D.; Richard G. Connor, M.D.; Emilio D. Echevarria, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Richard S. Hodes, M.D.; Robert G. Isbell, M.D.; Victor H. Knight Jr, M.D.; Thomas E. McKell, M.D.; Robert E. McCammon, M.D.; Robert J. Qualey, M.D.; Ralph E. Rydell, M.D.; Ronald L. Seeley, M.D.; William M. Trice, M.D.; James A. Winslow Jr, M.D.; Student, Alexander S. Gross.

INDIAN RIVER—Paul Graham, M.D. (Absent—Donald L. Ames, M.D.)

LAKE—Frederick C. Andrews, M.D.; Joseph E. Holland, M.D.; Robert H. Hux, M.D.

LEE—Cecil C. Beehler, M.D.; Larry P. Garrett, M.D.; Francis L. Howington, M.D.; H. Quillian Jones Jr, M.D.; Stephen R. Zellner, M.D.

MADISON—(Absent—William J. Bibb, M.D.)

MANATEE—Thomas R. Busard, M.D.; George C. Gallati, M.D.; Julian Giraldo, M.D.; Michael G. Ryan, M.D.

MARION—C. Brooks Henderson, M.D.; James L. McLaughlin, M.D.; Samuel L. Renfroe, M.D.

MARTIN—Fred S. Carter, M.D.; (Absent—Guy R. Hopper, M.D.)

MONROE—Robert D. Carraway, M.D.; Ronald H. Chase, M.D.

NASSAU—(Absent—E. Trier Morch, M.D.)

OKALOOSA—David R. Arrowsmith, M.D.; Samuel M. Atkinson Jr, M.D.

ORANGE—Edward Ackerman, M.D.; Clarence M. Gilbert, M.D.; William E. Hoffmeister, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; Charles T. Price, M.D.; James F. Richards Jr, M.D.; Robert N. Serros, M.D.; Edward W. Stoner, M.D.; John P. Taggart, M.D.; T. Byron Thames, M.D.; Cecil B. Wilson, M.D. (Absent—Robert B. Trumbo, M.D.)

OSCEOLA—Gilberto Perez, M.D.

PALM BEACH—Vernon B. Astler, M.D.; Elizabeth J. Barice, M.D.; Richard C. Cavanagh, M.D.; Ralph R. Eastridge, M.D.; Lee A. Fischer, M.D.; James R. Forlaw, M.D.; Luis R. Guerrero, M.D.; James M. Johnson, M.D.; V. A. Marks, M.D.; Richard B. Moore, M.D.; William J. Romanos Jr, M.D.; James F. Smith, M.D.; Joel F. Smith, M.D.; Milton R. Tignor Jr., M.D.; Dick L. Eldik, M.D. (Absent—Ben R. Thebaut Jr, M.D.)

PANHANDLE—James T. Cook Jr, M.D.; Karl S. Franz, M.D.

PASCO—Kong D. L. Chiang, M.D.; Vincent G. Cotroneo, M.D.; David A. Johnson, M.D.

PINELLAS—Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Michael H. Diamond, M.D.; Charles K. Donegan, M.D.; John M. Hamilton, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr, M.D.; Morris J. LeVine, M.D.; Jack A. MaCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; William H. Schmid, M.D.; Bruce P. Smith, M.D. (Absent—John M. Thompson, M.D.; Walter H. Winchester, M.D.)

POLK—Ronald W. Case, M.D.; Thomas M. Caswall, M.D.; Saul B. Gerber, M.D.; John W. Grotfelty, M.D.; Wiley E. Koon, M.D.; Thomas E. McMicken, M.D.; John C. Moore, M.D.; David Stoler, M.D.

PUTNAM—Roy E. Campbell, M.D.

ST. LUCIE-OKEECHOBEE—Charles R. Cambron, M.D.; William H. Meyer Jr, M.D.

SANTA ROSA—David B. Young, M.D.

SARASOTA—John N. Carlson, M.D.; Kenneth C. Kiehl, M.D.; Martin F. Mihm, M.D.; Douglas R. Murphy, M.D.; Franklin H. Pfeifferberger, M.D.; Richard C. Rehmyer, M.D.; Karl R. Rolls, M.D.

SEMINOLE—Luis M. Perez, M.D.; Frederick J. Weigand, M.D.

SUWANNEE-HAMILTON-LAFAYETTE—(Absent—Alex Kish, M.D.)

TAYLOR—(Absent—John H. Parker, M.D.)

VOLUSIA—Grandy B. Barnard, M.D.; Charles R. DeArmas Jr, M.D.; Remigio G. Lacsamana, M.D.; Robert W. Lankford, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.

WALTON—(Absent—Howard F. Currie, M.D.)

WASHINGTON—(Absent—Muhammad I. Zafer, M.D.)

SPEAKER OF THE HOUSE—James B. Perry, M.D.

VICE SPEAKER—Franklin B. McKechnie, M.D.

Dr. Perry introduced Dr. Walker, President of PIMCO. Dr. Walker announced that the Reciprocal will offer increased limits on the professional liability insurance and that details would be announced in the near future.

Dr. Perry requested that Dr. Mullen announce the winners of the "Bent Instrument and Lost Ball" Golf Outing. First Place Low Gross with a 76 was Dr. Walt Cerrato; Second Low Gross at 80 was Dr. Seth Lowell; Third Low Gross at 81 was Dr. Tom Civitella. In the Low Net Division, Dr. Dennis Niner with a 70 for First Place, Dr. Ron Scott was Second at 72 on a match of cards with Dr. Dave Whitaker who also had a 72. A new award this year, the Courage Award, was presented to Dr. Gene Peek for having the courage to post his score.

Dr. Mullen also announced the top three winners of the 1982 Health Run. In First Place with a running time of 16:37 was Harvey Robles, a medical student; Second Place with a time of 17:54 was Dr. C. Fenner McConnell; and in Third Place with a time of 18:35 was Dr. Richard Janovsky.

Dr. Mullen then introduced Dr. Leonard Wyle of the AMPAC Board to the House as an honored guest.

The Distinguished Layman Award was presented by Dr. Mullen to Mr. Harlow J. Heneman of Sarasota. Mr. Heneman was escorted to the podium by Dr. Martin F. Mihm and President-Elect, Dr. Robert E. Windom.

Distinguished Layman Award

Mr. Harlow J. Heneman

Whereas, Harlow J. Heneman of Sarasota, Florida, helped organize and is now the Chairman of the Board of Trustees of the Sarasota Memorial Hospital Foundation which has amassed assets in excess of eight million dollars which can be used by Sarasota Memorial Hospital to continually upgrade the services provided by that institution; and

Whereas, Harlow J. Heneman has served as a medical consultant to twelve hospitals, professional health societies and medical schools across the country; and

Whereas, This distinguished individual directed a study on the National Intern and Resident Matching Program for the American Medical Association, the American Hospital Association and the Association of American Medical College; and

Whereas, This notable author has written and co-written publications pertaining to medical topics, leadership and education; and

Whereas, He is a former President of the Sarasota County Library Fund, Inc., which raised over \$2,000,000 to build the Selby Library for Sarasota County; and

Whereas, His efforts with the Ringling Museum of Art as a member and chairman of the Board have made it one of the most outstanding art galleries in the United States today; and

Whereas, Harlow J. Heneman is the Vice Chairman of the Board of Trustees of the Mote Scientific Laboratory and is a member of the Board of Trustees of the Selby Botanical Gardens; and



Mr. Harlow J. Heneman of Sarasota (second from right) receives FMA's Distinguished Layman Award from President Sanford A. Mullen, M.D., while Martin F. Mihm, M.D. (left), President of the Sarasota County Medical Society, and FMA President-Elect Robert E. Windom, M.D., look on approvingly.



Mr. K.B. Meurlott of Gainesville (left in left picture) was one of the top winners in the Annual Awards for Excellence in Medical Journalism. Here he receives his award from FMA President Sanford A. Mullen, M.D. In right photo, Ms. Kathy Lattimer of WVOJ-Radio in Jacksonville accepts first place in the radio division as William P. Booras, M.D., President of the Duval County

Whereas, Harlow J. Heneman continues to serve his community, the state of Florida and the nation with his talent, energy and time; therefore be it

RESOLVED, That upon the unanimous vote of the Board of Governors, the Florida Medical Association at its 108th Annual Meeting in Hollywood, Florida, May 5-9, 1982, presents to Harlow J. Heneman its Distinguished Layman Award.

Mr. Heneman expressed his appreciation of the award.

Dr. Mullen presented the Annual Awards for Excellence in Medical Journalism, conducted by the FMA for the news media and independent writers and producers throughout the State of Florida. This portion of the program was particularly pleasurable to Dr. Mullen since he related to it both professionally through his family and was also a judge for this contest. The other three judges of the contest, Dr. Daniel B. Nunn, Editor of *The Journal* and chief judge; Mr. John Rodgers, Director of Public Relations of The Charter Company who was not in attendance due to previous commitments; and Mr. Robert Appelman, Creative Director of Florida Production Center, were introduced to the House. Dr. Mullen commended them highly for their dedication in listening to all the radio tapes, viewing all of the television tapes, and hours spent reading the many print articles that were submitted.

There were a number of various categories for the media to enter and the judges selected First and Second Runners Up as well as First Place winners in each of the categories. First and Second Runners Up received certificates of recognition while the First Place winners were presented awards and a \$500 check for their contributions to informing and educating the public on the positive aspects of organized medicine.

In the magazine category, Ms. Mary Thompson and Ms. C. L. Conroy of *Reflex Magazine*, an employee-patient publication of Hialeah Hospital, won Second and First Runners Up, respectively.

The winning articles were "Life Flight" by Ms. Thompson and "CT Scanners" by Ms. Conroy. Mr. K. B. Meurlott, Managing Editor of *The Independent Professional* located in Gainesville, was First Place Winner for his article "Medical Board Clears Lake City Obstetrician of Malpractice Charges." Mr. Meurlott was commended for his very thoroughly researched, indepth article.

In the newspapers category, the contest was divided into two areas: publications with circulation of less than 50,000 and for circulation over 50,000. In the newspapers with circulation less than 50,000, Ms. Neysa S. Tice of the *Lake Placid Journal* was Second Runner Up for her article "Doctor/Wife Team Operate Medical Facility." Jane Shealy of the *Cocoa Tribune* won First Runner Up for her article "One Error, 5 Fewer Days to Live." First Place winner, Mrs. Sue Burgess of the *Jensen Beach Mirror*, won for her series on the Martin Memorial Hospital.

In the newspaper category of over 50,000 circulation, Ms. Naunton of the *Miami Herald* was Second Runner Up for various medical articles throughout the year. Mr. Phil Kloer of *The Florida Times-Union* was First Runner Up for "A Good Death."

also Runner Up in this year's Pulitzer Prize competition. Mr. Paul Tash of the *St. Petersburg Times* and Mr. Richard Koenig, formerly with *The Times* and now with *The Wall Street Journal* shared First Place for their winning series on St. Petersburg nursing homes.

Turning to the electronic media, Mrs. Donna Kelly of WDBO radio in Orlando was Second Runner Up and Ms. Marsha Timmons of WUSF-FM radio in Tampa won First Runner Up. This was the second time Ms. Timmons received one of the certificates in the radio competition. Her winning entry was "New Hope for Diabetics." From Duval County, Ms. Kathy Lattimer of WVOJ-AM was First Place winner with her program on "Drug Use and Abuse."

In the final category of television, Second Runner Up was Mr. Greg Wayland of WTSP-TV in St. Petersburg with his television report "Rebuilding the Human Machine" which tied in very closely with the Annual Meeting scientific theme, the Process of Aging. Both the First Runner Up, Mr. Art Carlson of WPLG-TV in Miami, and the First Place winner, Mr. Al Reuchel of WBBH-TV in Ft. Myers, had been winners in previous years Journalism Contests. Mr. Carlson did an outstanding program entitled "Anesthesia . . . Delayed Stress Syndrome . . . Radial Keratotomy." Mr. Reuchel, recipient last year of the special President's Plaque for his community oriented and highly effective series "The Cancer Time Bomb," won with his entry "The Unhealthy Costs of Health Care."

Dr. Mullen congratulated all of the winners and said that the Florida Medical Association was profoundly grateful to them for their time and efforts in communicating medical and health topics to the public, thereby keeping the residents of Florida well informed.

Dr. Mullen then announced a new awards program of FMA, the Medical Speakers Awards for 1982.

For a number of years the American Medical Association sponsored a national program for medical speakers with several specific categories.

Last year, during its restructuring, AMA chose to discontinue this worthwhile project. FMA's Public Relations Officer, Dr. Vernon B. Astler, recommended that FMA undertake this project on a statewide basis. A \$100 cash award to the county medical societies having First Place winners was offered. In the Television Talk Show category, Second Runner up was the Broward County Medical Association for a program on plastic surgery produced by its Executive Director, Mr. Bill Stafford. "To Your Health," featuring Dr. Patricia C. Cowdery from Duval County was First Runner Up. First Place winner was "Cancer of the Skin," Palm Beach County Medical Society, produced by the society executive, Mr. Mike Lopez. The Palm Beach County program has now been seen on television live for the 22nd consecutive year and was given the distinction of being recognized by AMA as the best television talk show in America.

There was the unique situation in the category of Television Host of both winners coming from Sarasota County Medical Society. FMA President-Elect Robert E. Windom, M.D., was the winner for the program he did featuring subject matter of "How to do Dialysis" and for presentation before a Professional Audience, Dr. James D. Kingham was a First Place winner for his series "Retinal Disease." Each of the award recipients expressed their appreciation.

The Malpractice Prevention Award was next announced by Dr. Mullen.

The Malpractice Prevention Award, also a new award in this year's Awards program, stemmed from a request from the leadership of the Florida Physicians' Insurance Reciprocal (FPIR) to the FMA to establish awards to point out and commend those



The Palm Beach County Medical Society and two Sarasota physicians were the top winners in the new Medical Speakers Awards Program. In left photo, Palm Beach County Medical Society Executive Vice President Mike Lopez accepts his Society's award from FMA President Sanford A. Mullen, M.D., while Lee A. Fischer, M.D. and V.A. Marks, M.D., both of Palm Beach County, look on. President-Elect Robert E. Windom, M.D. (center in right picture) was cited as the first-place television host. Sarasota CMS President Martin Mihm, M.D., displays the award made to James D. Kingham, M.D., who was not present.



Members of the 1981-82 Board of Governors gathered for the last time. Front row (left to right) Past President T. Byron Thames, M.D.; Secretary Luis M. Perez, M.D.; Vice-President Gerold L. Schiebler, M.D.; President Sanford A. Mullen, M.D.; President-Elect Robert E. Windom, M.D.; Treasurer J. Russell Forlaw, M.D.; and Francis C. Coleman, M.D. Back row: Dick L. Van Eldik, M.D.; Eugene G. Peek, M.D.; J. Lee Dockery, M.D.; Thomas E. McKell, M.D.; Robert N. Webster, M.D.; Mr. James Deming, Student Member; Rufus K. Broadaway, M.D.; Speaker of the House James B. Perry, M.D.; and Vernon B. Astler, M.D..

who have taken innovative steps to educate and/or assist others in our profession faced with the problems of medical malpractice. It was established that any physician member of the Reciprocal, or team of physicians, or hospital administrator, or risk managers, clinic managers, and other individuals who during the year presented timely programs, produced a publication or offer to help in the defense of a physician under possible malpractice threat be considered for recognition. Broward County Medical Association and Duval County Medical Society tied for First Runner Up for their television programs explaining the problems and the cost to the public of malpractice litigation presented in their respective locales. The First Place plaque was awarded to the Florida Chapter, American College of Emergency Physicians for its efforts in membership education on the subject of malpractice prevention. The specialty group was commended for its multifaceted, year-long program and cited as an outstanding example of informative and educational materials deserving both acknowledgement and appreciation.

Dr. Mullen then asked Dr. J. Robert Qualey and Dr. Richard G. Connar to escort Mrs. Amelia Hapke to the podium to receive a Certificate of Grateful Recognition for her dedicated and loyal service

through the years to Hillsborough County Medical Association.

Certificate of Grateful Recognition

Whereas, Amelia Hapke, of Tampa, Florida, has rendered distinguished and able service to the medical profession since 1955; and

Whereas, This outstanding individual was the first employee of the Hillsborough County Medical Association as a part-time secretary; and

Whereas, This eminent lady, through her dedication and loyal devotion, helped bring the Hillsborough County Medical Association from an organization of less than 200 physicians in 1955 to over 900 members in 1980, making it one of the largest county medical societies in the state of Florida; and

Whereas, Amelia Hapke retired as Executive Vice President of the Hillsborough County Medical Association in December 1980 after 25 years of service; therefore be it

RESOLVED, That a Special Recognition Award be presented to Amelia Hapke as a token of the warm regard and respect that the officers, members and executive staff of the Florida Medical Association hold for the many years of outstanding service rendered by this devoted individual.

Dr. Perry, Speaker, requested that the members of Reference Committee No. I come to the podium to give their report.

Report of Reference Committee No. I

Health and Education

Dr. C. Fenner McConnell, Chairman, and his committee came forward to present the report of Reference Committee No. I, Health and Education.

REPORT A of the

Board of Governors

Recommendation A-1 was adopted.

The Reference Committee moved an amendment to Recommendation A-2 by adding "That the County Medical Societies address the issue of liability and monitor the prescribing of drugs." The motion carried and Recommendation A-2 was adopted as amended.

Recommendation A-3 was adopted.

Recommendation A-4 was adopted.

Report A of the Board of Governors was adopted as amended.

Report A of the

Board of Governors

Sanford A. Mullen, M.D., Chairman

Board Actions of Major Importance

House of Delegates Referrals

Resolution 81-5 — Physician's Assistants. — This resolution was not adopted but referred to the Board of Governors for further consideration.

RESOLUTION 81-5

RESOLVED, That the Board of Medical Examiners limit all new Physician's Assistants certificates to be used in low physician density areas, thus providing increased health care delivery in rural areas and simultaneously decrease their cost effectiveness in urban areas; and be it further

RESOLVED, That physicians who employ a Physician's Assistant must be present on the premises when the Physician's Assistants are involved in patient care; and be it further

RESOLVED, That the employing physician should actively and properly identify the Physician's Assistant; and be it further

RESOLVED, That there should be no presigned prescriptions available; and be it further

RESOLVED, That patients requiring referral should be examined by the employer physician prior to referral.

The Board of Governors referred this matter to the Council on Legislation for review with input as necessary from Dr. Robert Webster as the SBME representative on the Board of Governors and from the Council on Specialty Medicine. In reviewing the resolution, it was pointed out that presigned prescriptions are prohibited by law. The Florida Academy of Family Physicians, which serves as the liaison with the Physician's Assistants, has been requested to attempt to work with that group in resolving the concerns expressed in the resolution.

FMA Councils and Committees

COUNCIL ON SCIENTIFIC ACTIVITIES

1982 Annual Meeting — The Board established the format for the 1982 Annual Meeting and approved "The Process of Aging" as the scientific theme. FMA members can earn up to 20 hours of continuing medical education credit during four days of scientific program scheduling.

FMA Journal — The Board extended its appreciation and commendations to Daniel B. Nunn, M.D., of Jacksonville, Editor of *The FMA Journal*, for the continuing excellence of *The Journal*. The Board also thanked the entire editorial board and those who have participated in *The Journal's* publication for their individual and collective contributions. The Board noted with particular interest and pleasure, the five excellent special issues published during the past year and the planned changes in the format of *The Journal* which is part of an ongoing effort to further enhance the quality of the physical appearance of *The Journal* as well as the contents.

Designation of Historical Sites/Medical Museums — In accordance with the criteria approved by the House of Delegates at the 1981 Annual Meeting for designating a historical site or medical museum in Florida, the Board approved historical site designations for:

- The John Robb House, Gainesville
Alachua County Medical Society
- Old St. Lukes Hospital, Jacksonville
Duval County Medical Society
- The Alamo, Miami
Dade County Medical Association

CME Survey Fees — The Board approved a fee of \$100 to be charged for all continuing medical education accreditation resurveys due on and after January 1, 1982.

Accreditation Council for Continuing Medical Education — The Board requested that efforts be made to obtain the appointment of a practicing physician from the southeast to the Accreditation Council for continuing medical education.

COUNCIL ON SPECIALTY MEDICINE

Specialty Groups Legislative Guidelines — The Board reviewed proposed guidelines for legislative activities submitted by the Council on Specialty Medicine for FMA-recognized specialty groups to insure the coordination of specialty group legislative objectives with those of the FMA.



Reference Committee I considered matters related to Health and Education. Left to right: Elizabeth J. Barice, M.D.; Richard C. Clay, M.D.; Ms. Judi Nolan, Recorder; C. Fenner McConnell, M.D., Chairman; James T. Cook III, M.D.; and Joseph F. Sullivan, M.D.

RECOMMENDATION A-1

THAT THE HOUSE OF DELEGATES ADOPT THE FOLLOWING GUIDELINES FOR LEGISLATIVE ACTIVITY BY FMA-RECOGNIZED SPECIALTY GROUPS:

STATEMENT OF POLICY

IT IS ESSENTIAL FOR THE FMA TO DEVELOP A PROGRAM OF LEGISLATIVE ACTIVITY THAT WILL PROVIDE THE NECESSARY AND APPROPRIATE ROLE FOR FMA-RECOGNIZED MEDICAL SPECIALTY GROUPS IN THEIR RELATIONSHIPS WITH THE LEGISLATURE.

PERIODICALLY FMA-RECOGNIZED MEDICAL SPECIALTY GROUPS WILL HAVE INTERESTS AND CONCERNS THAT ARE SPECIFIC TO THEM AND NOT NECESSARILY OF MAJOR INTEREST AND CONCERN TO THE FMA AS A WHOLE.

THOSE SPECIALTY GROUPS WITH PARTICULAR INTERESTS AND CONCERNS SHOULD HAVE THE PRIVILEGE OF DEVELOPING LEGISLATIVE PROGRAMS OF THEIR OWN, PROVIDED THAT THESE PROGRAMS ARE NOT IN CONFLICT WITH FMA POLICY AND PROVIDED THAT THESE PROGRAMS ARE COORDINATED WITH THE CHAIRMAN OF THE COUNCIL ON LEGISLATION.

THE CHAIRMAN OF THE COUNCIL ON LEGISLATION IN CONSULTATION WITH THE CHAIRMAN OF THE COUNCIL ON SPECIALTY MEDICINE SHALL DEVELOP A SET OF GUIDELINES, SUBJECT TO APPROVAL BY THE BOARD OF GOVERNORS, TO GOVERN THE DETAILS OF THE LEGISLATIVE ACTIVITIES OF THE SPECIALTY GROUPS. THESE GUIDELINES MAY BE MODIFIED BY THE CHAIRMAN OF THE COUNCIL ON LEGISLATION OR CHAIRMAN OF THE COUNCIL ON SPECIALTY MEDICINE FROM TIME TO TIME AS EXPERIENCE AND CIRCUMSTANCES DICTATE PROVIDED THAT THERE IS AGREEMENT BY THE OTHER CHAIRMAN AND APPROVAL BY THE BOARD OF GOVERNORS.

THE COUNCIL ON SPECIALTY MEDICINE SHALL DEVELOP APPROPRIATE GUIDELINES TO ASSURE COORDINATION OF THE LEGISLATIVE ACTIVITIES OF THE FMA SPECIALTY GROUPS.

GUIDELINES

THE ROUTE BY WHICH AN FMA-RECOGNIZED SPECIALTY GROUP SHOULD PRESENT ITS DESIRE TO PASS OR DEFEAT LEGISLATION SHOULD BE THROUGH THE COUNCIL ON SPECIALTY MEDICINE ON WHICH IT IS DULY REPRESENTED. THE COUNCIL SHOULD REVIEW THE LEGISLATION AND RECOMMEND TO THE FMA COUNCIL ON LEGISLATION A LEVEL OF SUPPORT OR OPPOSITION. IN SUCH CASES WHERE LEGISLATION PROPOSED BY A SPECIALTY GROUP IS IN DIRECT CONFLICT WITH THE POLICIES OF THE FMA, MEMBERS OF THAT PARTICULAR SPECIALTY GROUP MAY PROCEED TO ENGAGE IN LEGISLATIVE ACTIVITIES AS PRIVATE CITIZENS BUT NOT AS AN ORGANIZED GROUP.

PROFESSIONAL LOBBYISTS CONTRACTING WITH SPECIALTY GROUPS FOR LEGISLATIVE ACTIVITIES SHOULD WORK OUT PRIORITIES WITH THE MANAGER OF THE FMA CAPITAL OFFICE AND COORDINATE THEIR ACTIVITIES TO THOSE ISSUES PERTINENT TO GENERAL MEDICINE. IF TIME PERMITS, THEY SHOULD AT THE DIRECTION OF THE SPECIALTY GROUP USE THEIR SKILLS AND CONNECTIONS FOR LEGISLATIVE PROJECTS WHICH MAY NOT BE OF SPECIFIC CONCERN TO THE SPECIALTY GROUP, BUT WHICH ARE OF MUTUAL INTEREST TO THE SPECIALTY GROUPS AND FMA.

IN THE EVENT OF A DISAGREEMENT BETWEEN THE PROFESSIONAL LOBBYIST RETAINED BY THE SPECIALTY GROUP AND THE MANAGER OF THE FMA CAPITAL OFFICE, THE OPINION OF THE MANAGER OF THE CAPITAL OFFICE SHALL PREVAIL UNTIL SUCH TIME AS THE CONFLICT IS RESOLVED BY THE CHAIRMEN OF THE COUNCIL ON LEGISLATION AND THE COUNCIL ON SPECIALTY MEDICINE

IN CONSULTATION WITH THE OFFICERS OF THE SPECIALTY GROUP.

IF LEGISLATIVE ACTIVITIES OF THE SPECIALTY GROUP REQUIRE IMMEDIATE ACTION, THE SPECIALTY GROUP SHOULD CONTACT THE CHAIRMAN OF THE COUNCIL ON SPECIALTY MEDICINE OR THE FMA EVP TO ASSURE EXPEDITIOUS ACTION SO AS NOT TO JEOPARDIZE THE LEGISLATIVE PROGRAM OF THE SPECIALTY GROUP.

RESPONSIBILITIES

THE FOLLOWING RESPONSIBILITIES HAVE BEEN DEVELOPED TO ASSURE THE PROPER COORDINATION OF ALL LEGISLATIVE ACTIVITIES.

COUNCIL ON SPECIALTY MEDICINE:

- NOMINATE LIAISON REPRESENTATIVES TO MEET WITH COUNCIL ON LEGISLATION.
- CLEAR POLICY IN INDIVIDUAL AREAS THROUGH SPECIALTY GROUPS FOR RECOMMENDATION TO COUNCIL ON LEGISLATION FOR APPROVAL AS LEGISLATIVE OBJECTIVES.
- INFORM SPECIALTY GROUPS OF FMA LEGISLATIVE PROGRAM AND COORDINATE PRIORITIES WITH THOSE OF SPECIALTY GROUPS.

COUNCIL ON LEGISLATION:

- INFORM SPECIALTY GROUPS ON LEGISLATIVE ITEMS AFFECTING THEM.
- ASSIST SPECIALTY GROUPS IN PREPARING LEGISLATIVE PROGRAMS FOR INTRODUCTION.
- ASSIST SPECIALTY GROUPS IN PROMOTING APPROVED LEGISLATIVE OBJECTIVES.
- GIVE ASSISTANCE AND ADVICE TO SPECIALTY GROUPS IN ORGANIZATION FOR LEGISLATIVE ACTION.
- APPROVAL OF LEGISLATIVE OBJECTIVES OF SPECIALTY GROUPS TO BOARD OF GOVERNORS.
- PROVIDE GENERAL SUPERVISION NECESSARY TO INSURE COORDINATION OF TALLAHASSEE ACTIVITIES OF SPECIALTY GROUP STAFF.
- INVITE REPRESENTATIVES OF SPECIALTY GROUPS WITH TALLAHASSEE PROFESSIONAL LOBBYIST REPRESENTATIVE TO ALL COUNCIL ON LEGISLATION MEETINGS.
- APPROVE HIRING AND RETENTION OF TALLAHASSEE PROFESSIONAL LOBBYIST REPRESENTATIVES BY SPECIALTY GROUPS THROUGH CHAIRMAN OF COUNCIL ON LEGISLATION. SUGGESTED METHOD IS TO CONTRACT BY LETTER AGREEMENT THROUGH THE FMA.
- ATTEND MEETINGS OF SPECIALTY GROUPS AS REQUESTED TO ASSIST IN COORDINATION OF LEGISLATIVE OBJECTIVES.
- PROVIDE LEGISLATIVE INFORMATION AND ADVISORY SERVICE TO SPECIALTY GROUPS. THIS WILL BE SUBJECT TO CHANGE FOR EXTRAORDINARY OR CONTINUING SERVICE.

SPECIALTY GROUPS:

- GET LEGISLATIVE OBJECTIVES TO COUNCIL ON MEDICINE NO LATER THAN 165 DAYS PRIOR TO THE START OF THE NEXT LEGISLATIVE SESSION.
- KEEP COUNCIL ON LEGISLATION INFORMED OF ANY PROPOSED CHANGES.

- GIVE POLICY GUIDANCE TO FMA ON LEGISLATIVE OBJECTIVES IN AREA OF EXPERTISE — E.G., EYE CARE AND OPHTHALMOLOGISTS.
- APPOINT PHYSICIAN IN TALLAHASSEE TO SERVE AS LIAISON WITH FMA CAPITAL OFFICE.
- DESIGNATE REPRESENTATIVE TO MAINTAIN COORDINATION ON LEGISLATIVE ACTIVITIES WITH FMA.

LOBBYIST FOR SPECIALTY GROUPS:

- KEEP CAPITAL OFFICE INFORMED OF ALL PROGRAMS AND OBJECTIVES OF SPECIALTY GROUPS, TO INCLUDE ALL DECISIONS MADE BY GROUP OR EXECUTIVE COMMITTEE IN AREA OF LEGISLATION OR REGULATION.
- KEEP CAPITAL OFFICE INFORMED OF ALL PROBLEMS ENCOUNTERED BY GROUP IN TALLAHASSEE IN ORDER THAT FMA ASSISTANCE MIGHT BE ENLISTED AS NECESSARY.
- KEEP MANAGER OF CAPITAL OFFICE INFORMED OF OVERALL PLANS FOR ACHIEVING LEGISLATIVE OBJECTIVES TO INCLUDE LEGISLATIVE CONTACTS TO BE MADE AND PLANS FOR PHYSICIAN ACTIVITY IN TALLAHASSEE AND IN FIELD.
- SOLICIT ASSISTANCE OF FMA IN CARRYING OUT GOALS OF SPECIALTY GROUPS.

Doctor of the Day Program — The Board approved a Doctor of the Day Program for physicians and their families to be conducted in conjunction with the FMA Annual Meeting and Leadership Conference to be coordinated by the Chairman of the Council on Specialty Medicine with the Chairman of the Council on Scientific Activities.

Sarasota Senior Friendship Center — The Board of Governors considered a report from the Council regarding a request from Florida Governor Bob Graham that the FMA support the Senior Friendship Center in Sarasota and endorse the concept for replication in other cities in Florida.



President-Elect and Mrs. Robert E. Windom, M.D. (left) visit with President and Mrs. Sanford A. Mullen, M.D.

RECOMMENDATION NO. A-2

THAT THE FMA ENDORSE STATEWIDE IMPLEMENTATION OF A PROGRAM OF DONOR HEALTH SERVICES SIMILAR TO THAT PRESENTLY OPERATING WITH THE SARASOTA SENIOR FRIENDSHIP CENTER FOR HEALTH CARE FOR INDIGENT SENIOR CITIZENS SUBJECT TO THE FOLLOWING CRITERIA:

- **THAT THE PHYSICIANS ENGAGED, CONTRACTED, UTILIZED OR EMPLOYED ARE PARTICIPATING ON A STRICTLY VOLUNTARY BASIS AND DO NOT RECEIVE ANY REMUNERATION.**
- **THAT ONLY PHYSICIANS LICENSED UNDER F.S. 458.317 OR RETIRED FULL LICENSED PHYSICIANS BE ALLOWED TO PARTICIPATE IN THIS PROGRAM.**
- **THAT THE PROGRAM PROVIDE SCREENING TO DETERMINE INDIGENT ELIGIBILITY.**
- **THAT THE HEALTH CARE PROVIDED BY THESE PHYSICIANS TO PATIENTS BE LIMITED TO:**

- **MEDICAL EDUCATION**
- **NUTRITION**
- **SELF CARE**
- **CONSULTATION AND PERSONAL USE OF MEDICATIONS**
- **HEALTH SCREENING**
- **DIAGNOSIS AND REFERRAL.**

- **THAT CARE REQUIRING SURGERY, HOSPITALIZATION, MULTIPLE-TESTING, X-RAYS AND COMPLEX LONG-TERM CARE BE REFERRED TO A PRIVATE PRACTITIONER.**
- **THAT THE PROGRAM ONLY SERVE THE MEDICALLY INDIGENT SENIOR CITIZEN.**
- **THAT THE PHYSICIANS PARTICIPATING UNDER LIMITED LICENSES DO NOT SEEK HOSPITAL PRIVILEGES.**
- **THAT THE PHYSICIANS PARTICIPATING IN THIS PROGRAM WRITE ONLY NON-NARCOTIC PRESCRIPTIONS.**
- **THAT THESE PHYSICIANS PRACTICE WITH THE APPROVAL OF THE LOCAL COUNTY MEDICAL SOCIETY.**
- **THAT THE COUNTY MEDICAL SOCIETIES ADDRESS THE ISSUE OF LIABILITY AND MONITOR THE PRESCRIBING OF DRUGS.**
- **THAT THIS PROGRAM BE UNDER THE SUPERVISION OF THE LOCAL PUBLIC HEALTH DEPARTMENT.**

Schedule II Drugs — The Board approved a recommendation that FMA investigate a requirement of the Department of Professional Regulation that physicians furnish the home address on Schedule II prescriptions.

Physician Treatment of their Immediate Families — The Board directed that the FMA investigate the apparent problem that exists regarding a Department of Professional Regulation rule prohibiting physicians from treating members of their immediate family and to take appropriate action as needed.

Third Party Payers — The Board authorized FMA to conduct a study of third party payers who continue to review charges and send written correspondence to patients which sometimes include disparaging remarks in reference to excessive charges.

Specialty Groups Recognition Program — The Board reviewed a report and recommendations from the Council regarding renewal of recognition of specialty groups and approved full continuing recognition of thirty-six specialty groups including:

- The Board approved a one-year probationary status for the Florida Neurosurgical Society.
- The Board also considered recommendations from the Council regarding modifications in the criteria for recognition.



FMA Past President and Mrs. George A. Palmer, M.D., visit with their son, George, Jr., a member of the FMA Capital Office Staff.

RECOMMENDATION NO. A-3

THAT THE HOUSE OF DELEGATES APPROVE MODIFICATIONS TO THE CRITERIA AND GUIDELINES OF THE FMA PROGRAM FOR RECOGNITION OF SPECIALTY GROUPS TO PROVIDE:

- **THAT UNDER THE CATEGORY "PROBATION", ANY DEVIATION IN EXCESS OF 10% FROM GUIDELINE I.H. AND THAT ANY SPECIALTY GROUP PLACED IN THE PROBATIONARY CATEGORY WHILE RETAINING ALL RIGHTS OF PARTICIPATION IN DELIBERATIONS OF THE COUNCIL, BE DENIED THE PRIVILEGE OF VOTING DURING THE YEAR OF PROBATION.**
- **THAT A SPECIALTY GROUP BE TERMINATED FROM THE PROGRAM IF IT DOES NOT SATISFY THE GUIDELINES AT THE END OF THE PROBATIONARY STATUS PROVIDED, HOWEVER, THAT THE SPECIALTY GROUP MAY REAPPLY AS A NEW SPECIALTY.**
- **THAT THE TIME FRAME FOR CONTINUING RECOGNITION PROVIDES FOR BIENNIAL REVIEW ON AN ALTERNATING BASIS BEGINNING IN 1983 WITH AN ODD/EVEN NUMBERING SYSTEM WITH ODD NUMBERED REVIEWS TO BE COMPLETED FOR APPROVAL IN 1984 AND THE EVEN NUMBERED TO BE APPROVED IN 1985.**

Florida Society of Ophthalmology Resolution — The Board reviewed a resolution submitted by the Florida Society of Ophthalmology relating to procedure codes used under Medicare Part B for reimbursing non-medical practitioners for treatment of the eye condition Aphakia.

RECOMMENDATION NO. A-4

THAT THE HOUSE OF DELEGATES APPROVE FMA SUPPORT FOR THE FLORIDA SOCIETY OF OPHTHALMOLOGY RESOLUTION REGARDING THE MEDICARE PART B PROVISION FOR REIMBURSING NON-MEDICAL PRACTITIONERS FOR THE TREATMENT OF APHAKIA:

WHEREAS, IT HAS COME TO THE ATTENTION OF THE FLORIDA SOCIETY OF OPHTHALMOLOGY THAT EYE EXAMINATIONS FOR TREATMENT OF THE CONDITION OF APHAKIA BY NON-MEDICAL PRACTITIONERS (OPTOMETRISTS) HAVE BEEN ASSIGNED IDENTICAL PROCEDURE CODES FOR REIMBURSEMENT UNDER THE MEDICARE PART B PROGRAM AS THOSE ASSIGNED TO PHYSICIAN PROVIDERS (OPHTHALMOLOGISTS); AND

WHEREAS, THESE CODES SPECIFICALLY IDENTIFY OPHTHALMOLOGICAL SERVICES, PROVIDING FOR SPECIFIC DIAGNOSTIC AND TREATMENT PROGRAMS UNDER PHYSICIANS SERVICES, NOT SPECIFICALLY LIMITED TO APHAKIA; AND

WHEREAS, NON-MEDICAL PROVIDERS (OPTOMETRISTS) DO NOT PROVIDE IDENTICAL EXAMINATIONS FOR THE CONDITION OF APHAKIA AS THOSE PROVIDED BY PHYSICIAN PROVIDERS (OPHTHALMOLOGISTS); AND

WHEREAS, IDENTICAL CODES IMPROPERLY IMPLY EQUAL IN PURPOSE OR EXTENT PROVIDED BY THE DISSIMILAR PROVIDERS AND WHICH WILL IMMEDIATELY LEAD TO INCREASED COSTS TO THE MEDICARE PART B PROGRAM; THEREFORE BE IT

RESOLVED, THAT NEW SEPARATE PROCEDURE CODES PERTAINING TO THOSE SERVICES PROVIDED BY NON-MEDICAL PRACTITIONERS (OPTOMETRISTS) FOR THE CONDITION OF APHAKIA BE DEVELOPED TO DISTINGUISH FROM THOSE SERVICES PROVIDED BY PHYSICIAN PROVIDERS (OPHTHALMOLOGISTS) FOR THE TREATMENT OF APHAKIA; AND BE IT FURTHER

RESOLVED, THAT ACCURATE DESCRIPTIVE TERMINOLOGY BE DEVELOPED TO REFLECT THE EXTENT OF THE LIMITED SERVICES PROVIDED BY THE NON-MEDICAL PRACTITIONER (OPTOMETRIST) FOR THE CONDITION OF APHAKIA; AND BE IT FURTHER

RESOLVED, THAT THE FLORIDA SOCIETY OF OPHTHALMOLOGY REQUESTS THAT THE FLORIDA MEDICAL ASSOCIATION ADOPT THIS RESOLUTION FOR ESTABLISHMENT AS A POLICY OF THE FLORIDA MEDICAL ASSOCIATION AND TO TAKE ALL NECESSARY ACTION TO SEE THAT THE INTENT OF THIS RESOLUTION IS IMPLEMENTED.

Report of the Council on Scientific Activities

Council on Scientific Activities

The Reference Committee noted that the national Accreditation Council for Continuing Medical Education (ACCME) has decided not to publish its proposed handbook regarding standards, evaluation and criteria for accreditation.

A motion was made that the House of Delegates instruct the AMA Delegates to request that the AMA Representatives to the ACCME urge the

publication of the ACCME Handbook. The motion carried.

The Report of the council on Scientific Activities was adopted.

Council on Scientific Activities Yank D. Coble Jr., M.D., Chairman

The Council on Scientific Activities met at Lake Buena Vista on January 30 and again at the Florida Medical Association Scientific Assembly. Additional Council work was conducted following meetings of the component committees attended by Council members. The Council's work is summarized under the headings of its component committees and subcommittees:

Committee on Medical Education

Henry M. Yonge, M.D., Pensacola, has completed a third highly successful year as Chairman of this Committee. In addition to statewide responsibilities, Dr. Yonge has represented the FMA at the national Accreditation Council for Continuing Medical Education (ACCME), including the meeting in Chicago for state medical society CME chairmen and staff members and the regular meeting of the ACCME including ten state representatives. Because of Dr. Yonge's efforts, the Florida CME Accreditation Program has been meshed effectively and cooperatively with the ACCME. However, in view of the disagreement with the national CME organizations, close monitoring by the FMA is indicated.

This Committee, formerly known as the Committee on Continuing Medical Education, exchanged names with the counterpart committee of the Florida Medical Foundation in June 1981. By dropping the "Continuing" from its title, the Committee on Medical Education identified its responsibility in all levels of medical education, from pre-med to CME. Enlargement of this Committee to 10 members and inclusion of the deans of the three state medical schools has enabled the Committee to cover its wide range of interests and responsibilities. Meanwhile, the Foundation's Committee on Medical Education added "Continuing" to its title, consistent with its exclusive concern with CME and its responsibility for co-sponsoring AMA Category I Continuing Education Activities.

1. **Annual Meeting Scientific Program:** Dr. Calvin W. Martin, Vice Chairman of the Medical Education Committee and Chairman of the Scientific Assembly, has produced another superb scientific program in collaboration with the FMA recognized specialty groups. The theme of this year's Scientific Assembly has been effectively carried out by the specialty groups. A highlight of the scientific program will be the Seminar on the Process of Aging on Thursday afternoon, May 6, featuring three outstanding guest speakers and chaired by the Dean of the University of South Florida College of Medicine, Dr. Andor Szentivanyi. Additional features will include a program on chemical dependency, a medical liability seminar, Pfizer "Dialogue" programs, Wyeth AutoTutors, and many technical, scientific and educational exhibits.

The changing economy and other difficulties have resulted in a significant lowering of attendance at continuing education programs throughout the country. The excellent offerings of the FMA and the extremely low cost of obtaining 20 hours of continuing medical education credit have resulted in the excellent attendance to date. However, it is important to assure that adequate pre-meeting publication and publicity be provided to potential attendees. Thus, the Subcommittee has made recommendations to hopefully assure that specialty group program chairmen are named sufficiently early to complete programs at an early date to provide attendees early notification of the full FMA Scientific Program. These recommended efforts

will include communication by the President of the FMA to the Presidents of the Specialty Societies and a calendar of deadlines by which to obtain names of scientific program chairmen and tentative programs and completed programs.

2. **Subcommittee on Accreditation:** Under the able leadership of Samuel E. Crockett, M.D., of Orlando, this group has again had an extremely busy year. The following CME accreditation actions have been taken by the Subcommittee and the Committee on Medical Education since the last Annual Meeting:

- A. **Florida Hospital**, Orlando, Florida — Accredited provisionally for two years (March 24, 1981 to March 23, 1983).
- B. **Halifax Hospital Medical Center**, Daytona Beach, Florida — Reaccredited for six years (March 10, 1981, to March 9, 1987).
- C. **Cedars of Lebanon Health Care Center**, Miami, Florida — Reaccredited for six years (June 2, 1981, to June 1, 1987).
- D. **Florida Medical Foundation Committee on Continuing Medical Education** — Reaccredited for six years (December 14, 1981, to December 13, 1987).
- E. **Winter Haven Hospital**, Winter Haven, Florida — Accredited Provisionally for two years (October 13, 1981, to October 12, 1983).
- F. **North Ridge General Hospital**, Ft. Lauderdale, Florida — Accredited provisionally for two years (November 21, 1981, to November 20, 1983).
- G. **Dade County Medical Association**, Miami, Florida — Reaccredited for six years (December 13, 1981, to December 12, 1987).
- H. **Parkway General Hospital**, North Miami Beach, Florida — Accredited provisionally for two years (December 17, 1981, to December 16, 1983).
- I. **Baptist Medical Center and Jacksonville Wolfson Children's Hospital**, Jacksonville, Florida — Accredited provisionally for two years (January 13, 1982, to January 12, 1984).

3. **Subcommittee on Program Approval:** CME providers in Florida continue to use regularly the Committee's program approval mechanism whereby CME programs are reviewed and approved for FMA Mandatory Credit. Approximately 350 such applications are serviced by the Subcommittee on Program Approval each year. Subcommittee Chairman Orris O. Rollie, M.D., of Orlando, and members Calvin W. Martin, M.D., of Arcadia, and David S. Hubbell, M.D., of St. Petersburg have provided exceptional service on these applications, reviewing each case thoroughly and at the same time providing fast turnaround.

4. **Other Activities:** The Committee has been monitoring the activities of other education-oriented groups, including the Accreditation Council for Continuing Medical Education (ACCME), the Alliance for Continuing Medical Education, and Florida's Community Hospital Education Council (CHCE). Representatives of the Committee have attended since the last Annual Meeting, two meetings sponsored by ACCME, a one-day seminar for state medical society CME chairmen and staff members assigned to CME, and a regular meeting of the ACCME to which representatives of 10 states were invited.

The Florida CME accreditation program has been meshed effectively and cooperatively with ACCME. While there seems to be a willingness on the part of the ACCME to cooperate with the FMA and other state associations, your Council and the Committee on Medical Education are concerned about (1) the shortage of practicing physicians on the ACCME; and (2) the total lack of representation from the Southeastern United States.

Committee on Scientific Publications

Daniel B. Nunn, M.D., is completing his second very successful year as Editor of *The Journal of the Florida Medical Association* and Chairman of the Committee on Scientific Publications. Remarkable improvements were made in *The Journal's* never-ending quest for the top spot on every FMA member's reading list.

The Committee has met three times since the 1981 Annual Meeting: on June 21, 1981, in Jacksonville; September 18, 1981 in Tampa; and on March 6, 1982 in Tampa. The latter was the annual joint meeting with the consulting editors and featured an address by Lois DeBakey, Ph.D., a medical communications expert.

1. **New Design:** A redesign of *The Journal* was scheduled to be implemented with the April issue. From cover to cover the publication will have a completely new look. New type faces and new formats will be introduced.

Approximately one year ago, the Committee on Scientific Publications commissioned Professor Paul Fisher of the University of Missouri School of Journalism to study *The Journal* and recommend graphic changes to provide better organization and a more pleasing appearance. Dr. Fisher's recommendations have been examined in detail by the editors; the redesign will be available for all members to see April 1982.

2. **Special Issues:** For several years special issues have been a hallmark of *The Journal*. Five outstanding special issues have been published in the past year. The traditional Historical Issue, edited as always by Dr. William M. Straight, featured in August 1981 a discussion of Florida's pioneering efforts in emergency medical services.

The September 1981 special issue commemorated the 10th anniversary of the University of South Florida College of Medicine. This significant contribution to Florida's medical historical literature was accomplished through the considerable organizational talents of the Guest Editor, Donn L. Smith, M.D., the College's founding Dean and now a Professor of Physiology.

The year 1982 brought us three consecutive special issues. First the Special FMA Auxiliary Issue was published in February under the expert guidance of the Guest Editor, Mrs. Mae White of Fort Lauderdale.

Charles P. Hayes Jr., M.D., of Jacksonville, assumed the Guest Editor responsibilities for the Special Issue on Health Care Financing published in March. This was a collection of papers presented at the Annual FMA Leadership Conference at Lake Buena Vista in January.

Finally, JFMA Assistant Editor Lee A. Fischer, M.D., of West Palm Beach, organized a third special issue, which was published in April and was devoted to "The Process of Aging," which also is the theme for the 1982 Annual Meeting Scientific Program.

In the past many special issues have won awards, and the Special Issue on Nutrition, published in 1979 and edited by Lewis A. Barness, M.D., of the University of South Florida College of Medicine, was published as a textbook, "Nutrition in Medical Practice."

3. **Covers:** *The Journal* continues to place a high priority on securing attractive covers to introduce each month's issue. To this end, Mrs. Dale Charneco, an award-winning artist from Orange Park and a member of the FMA Auxiliary was asked and she graciously agreed to give her considerable artistic talents as a consulting editor in charge of covers.

Research Grants

The Council received no research grant applications during the year, and no grants were awarded.



Eugene A. Stead, M.D. (left) was an honored guest at a reception sponsored by the Duke University Medical School during the Annual Meeting. With him are FMA President-Elect Robert E. Windom, M.D., a Distinguished Alumnus of Duke, and Mrs. Windom.

Report of the Council on Specialty Medicine

The Report of the Council on Specialty Medicine was adopted.

Council on Specialty Medicine Arthur L. Eberly Jr., M.D., Chairman

The Council on Specialty Medicine meets approximately six times every two years and is made up of thirty-eight representatives of specialty groups which have been recognized by the Florida Medical Association. The Council meets several times each year and discusses items of information, takes action and makes recommendations to the FMA Board of Governors on issues of concern to the specialty groups represented on the Council. In the past year, only two committees of the Council have functioned:

Subcommittee on Specialty Recognition

This Subcommittee met on two occasions and considered the recognition applications of specialty groups applying for recognition on the Council.

Committee on Perinatal Funding

This special committee appointed by the Chairman, met one time in Tallahassee, Florida to consider and make recommendations to the Council on the status of perinatal funding in Florida and its future.

The Council met three times in 1981 and once in 1982 — February 21, 1981, July 25, 1981, December 12, 1981 and February 13, 1982.

Issues that the Council considered during 1981-82 were as follows:

1. **Specialty Group Legislative Guidelines:** The Council redrafted and clarified the guidelines in order to provide

continuity and coordination of specialty groups with the FMA legislative programs. These guidelines were forwarded to the FMA Board of Governors for their action in early September, 1981.

2. **Legislation:** The Council considered and made recommendations to the Council on Legislation on a number of issues of concern to specialty medicine:

- Opposition to the Certificate of Need legislation and administrative rules. This was primarily a reiteration of the Council's opposition to Certificate of Need legislation as the Board of Governors had previously addressed this issue.
- Advanced Registered Nurse Practitioners: The Council endorsed and made a recommendation of top priority support be given to the sponsorship of House Bill 903 from 1981 requiring registration of Advanced Registered Nurse Practitioner protocols.
- The Council on Specialty Medicine forwarded a recommendation to the Council on Legislation opposing funding proposals for schools of optometry in the State of Florida, because they felt there was an adequate number of optometrists at this time and in the foreseeable future.
- The Council forwarded a recommendation to the Council on Legislation reaffirming its support for the Community Hospital Education Act as it now exists.

The Council felt it was important to communicate to the Council on Legislation its support for the Act and opposition to any radical changes as was proposed in the 1981 Legislative Session.

3. **Biannual Recognition Program:** The Council reviewed and approved a number of applications for specialty recognition (all of which are presently serving on the Council). The Council has recommended Full Recognition for 36 of 38 specialties on the Council and Probationary for one of the specialties. As of the last meeting of the Council (February 13, 1982) the Florida Chapter of the International College of Surgeons had not submitted an application, therefore could not be considered by the Council at its last meeting. That application has now been forwarded to the Council and is under consideration at this time.

The Council and its Subcommittee on Recognition forwarded to the FMA Board of Governors recommendations to streamline and simplify the Recognition Program as well as recommendations for modification to the program in order to make it more enforceable.

4. **Board Referrals:** The Council considered only one Board Referral during the 1981-82 FMA year, which was a referral prompted by an inquiry from Florida Governor Bob Graham. This referral requested the Council's consideration and recommendation to the FMA Board endorsing the Sarasota Senior Friendship Center concept for implementation statewide. The Council researched and discussed the issues at two meetings on July 25, 1981 and December 12, 1981 and made a recommendation to the FMA Board of Governors that the Sarasota Senior Friendship Center concept be endorsed for implementation as a statewide program with certain stipulations and reservations.

5. **1982 Relative Value Studies:** The Council was mailed copies of the Draft 1982 Relative Value Study and considered those in concert with the FMA Committee on Relative Value Studies and the FMA consultants in a meeting on December 12, 1981. The discussion was thorough and fair and resulted in some positive input by the Council. The Council representatives spent numerous hours reviewing and commenting on their particular specialty areas in reference to the Draft 1982 Relative Value Study. The Council representatives and specialty officers spent a number of hours over the Christmas holidays reviewing and making recommendations on the RNE's (Relativity Not Established).

6. **Speakers Before the Council:** Over the year a number of speakers appeared before the Council on Specialty Medicine to share ideas and provide information to the Council at its meetings. Among the speakers were: Sanford A. Mullen, M.D., President of the FMA; Robert E. Windom, M.D., President-Elect of the FMA; Louis C. Murray, M.D., Chairman, Council on Legislation; Francis C. Coleman, M.D., President of FLAMPAC; Charles P. Hayes Jr., M.D., Chairman, Council on Health Care Financing; Joel Mattison, M.D., Chairman, Committee on Relative Value Studies; several physicians staffing the Sarasota Senior Friendship Center and its Donor Health Program including Irwin R. Porter, M.D.; Sam Waterson, M.D.; Henry Moreton, M.D., Public Health Officer; and Gilbert Dorence, M.D. Also appearing before the Council were Raymond Alexander, M.D., and Peter Pons, M.D., staff for the FMF-EMS Project.
7. **Miscellaneous:** Numerous other issues were discussed and considered by the Council, most of which were informational items. Among these items were some of the new rules and regulations which affect Medicare, Medicaid and Workers' Compensation. Also discussed were all of the various programs which affect specific specialties and their impact on medicine as a whole.



Charles F. Tate, M.D. (foreground) and Edward R. Annis, M.D., both of Miami, listen as a Reference Committee report is read.

**Report of the
Florida Medical Foundation
Committee on Continuing Medical Education
Medical Student Loans
Nutrition Textbook**

In considering the referred items in the Florida Medical Foundation Report, the Reference Committee had recognized deficiencies in funds for medical student loans.

A motion was made that the House of Delegates instruct the Florida Medical Foundation to investigate the feasibility of increased funding for student loans. The motion carried.

The items in the Florida Medical Foundation Report on Committee on Continuing Education, Medical Student Loans, and Nutrition Textbook, were adopted.

(See Report of the Florida Medical Foundation on page 583.)

**RESOLUTION 82-16
Cancer Programs in Hospitals
Hillsborough County Medical Association**

The Reference Committee moved an amendment to Resolution 82-16.

The amendment carried, and Resolution 82-16 was adopted as amended.

**RESOLUTION 82-16
Cancer Programs in Hospitals**

RESOLVED, That licensed hospitals in the state of Florida be encouraged to establish a cancer program; and be it further

RESOLVED, That the cancer programs strive to achieve accreditation by the American College of Surgeons Commission on Cancer.

The Chairman expressed his appreciation to all members of the Association who provided guidance and counsel. Special thanks were conveyed to Dr. Richard G. Connar and Dr. Charles J. Kahn, both whom represented the AMA Delegates at the meeting of the Reference Committee. Dr. McConnell also expressed his sincere appreciation to the members of the Committee and to the FMA staff, Mr. Edward D. Hagan, Mr. Jim McCloy, and Ms. Judi Nolan for their assistance in the preparation of the report.

The motion of the Reference Committee that the Report of Reference Committee No. 1 be adopted as amended carried.



U.S. Sen. Paula Hawkins was the guest speaker for the Annual Auxiliary-FLAMPAC Luncheon.

Report of Reference Committee No. II Public Policy

Dr. Robert H. Hux, Chairman, and his committee came forward to present the report of Reference Committee No. II, Public Policy.

Report B of the Board of Governors

During the Reference Committee's deliberations, it had noted that the report on the measles eradication campaign did not specify the type of measles. The motion of the Reference Committee that the item relating to a Florida measles eradication campaign be amended by adding "for both Rubella and Rubeola" carried.

It was also noted during the Reference Committee's deliberations, that there had been recent adverse media publicity concerning DPT immunizations. The Reference Committee recommended that the Florida Medical Association firmly support the continued DPT immunization program in spite of the adverse publicity because the benefits far outweigh the risks. The Reference Committee pointed out that this be accomplished by the Florida Medical Association, in conjunction with the Florida Pediatric Society, medically informing the public of the Florida Medical Association's position on this important subject.

The Reference Committee heard lengthy discussions on the problem of mail advertisements of look-alike drugs to lay people in Florida. The motion of the Reference Committee that the item relating to the unsolicited direct mail advertisements to lay people in Florida on look-alike drugs be amended by the substituting "media and mail advertisements to lay people in Florida on look-alike drugs which simulate controlled drugs and request that the State Attorney General determine if some controls on this type of advertising can be established" was carried.

The Reference Committee encouraged the Florida Medical Association to continue support of the previously passed recommendation of the House of Delegates which recommended that the DEA number not be pre-printed on the prescription pads to prevent forged prescriptions in obtaining Schedule II drugs.

The Reference Committee heard testimony regarding the report of the Committee on Emergency Medical Services. In view of the fact that during the last legislative session, no action was taken on Chapter 401, the Emergency Medical Services

statute which will sunset in October of 1982, the Reference Committee recommended that the Florida Medical Association urge the Governor of the State of Florida to take the necessary, appropriate action to continue Chapter 401 until the EMS study can be completed. A motion to adopt the Reference Committee's recommendation carried.

Report B of the Board of Governors was adopted as amended.

Report B of the Board of Governors Sanford A. Mullen, M.D., Chairman

FMA Councils and Committees

COUNCIL ON MEDICAL SERVICES

Measles Eradication Campaign — The Board received a report from the Council that during 1981, 25 percent of all the measles reported in the United States were located in the state of Florida.

RECOMMENDATION NO. B-1

THAT THE HOUSE OF DELEGATES APPROVE FMA ADOPTION OF A RESOLUTION IN SUPPORT OF THE NATIONAL CAMPAIGN TO ERADICATE MEASLES:

WHEREAS, THE CENTER FOR DISEASE CONTROL (CDC) MEASLES ELIMINATION INITIATIVE HAS BEEN VERY SUCCESSFUL TO DATE IN DRAMATICALLY DECREASING MEASLES TRANSMISSION; AND

WHEREAS, THE MAINTENANCE OF HIGH IMMUNIZATION LEVEL, COMPREHENSIVE K-12 SCHOOL IMMUNIZATION LAWS WITH EXCLUSIONARY PROVISIONS, AND THE SURVEILLANCE AND CONTROL OF OUTBREAKS HAVE BEEN A MAINSTAY OF THE ELIMINATION INITIATIVE; AND

WHEREAS, FLORIDA IS ONE OF THE FEW REMAINING AREAS OF MEASLES ENDEMICITY IN THE UNITED STATES, THEREFORE BE IT

RESOLVED, THAT THE FMA SUPPORT THE COMBINED EFFORTS OF THE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES AND THE DEPARTMENT OF EDUCATION IN THE IMPLEMENTATION OF THE NEW SCHOOL IMMUNIZATION LAW AND THAT DHRS/DOE LAUNCH A FLORIDA MEASLES ELIMINATION INITIATIVE, FOR BOTH RUBELLA AND RUBEOLA.

Look-Alike Drugs — The Board voted to express to the State Attorney General FMA's concern about the unsolicited direct mail advertisements in Florida on look-alike drugs with the request that he determine if some controls on this type of advertising can be established.

EMS Project — The Board of Governors authorized the Florida Medical Foundation to enter into a one-year contract with the Florida Department of Health and Rehabilitative Services effective December 1, 1981, whereby the Foundation shall:

- Analyze Florida's critical care capabilities.
- Develop a five-year EMS plan for the state.
- Provide medical direction to the state EMS office.

The Board approved the selection of Raymond H. Alexander, M.D., Gainesville, to serve as Medical Director for the EMS project and the selection of Peter Pons, M.D., Jacksonville, as Assistant Medical Director.

Critical Care Survey — The Board authorized the EMS project, subject to prior review by the Board of Governors, to publish the results of the FMA's 1978 Critical Care Survey by:

1. Sending each Florida hospital a copy of the Critical Care Survey analysis.
2. Providing the state EMS office, Department of HRS, a copy of the survey analysis as part of its reporting requirements under the project contract.

Report of the Council on Medical Services

There was a lengthy hearing regarding drug abuse. It was noted that Dilaudid is one of the most

frequently abused drugs and is increasingly becoming more of a problem. The Reference Committee moved to amend the report of the Committee on Drug Abuse by adding to the first paragraph, "They have found that one of the most frequently abused drugs was a prescription drug called Dilaudid." The motion carried.

The Reference Committee also called to the attention of the House of Delegates the article which appeared in the April issue of *The Journal of the Florida Medical Association*, page 315, entitled "FMA Committee on Drug Abuse Comments on Dilaudid Addiction."

The Report of the council on Medical Services was adopted as amended.

Council on Medical Services

Joseph T. Ostroski, M.D., Chairman

The Council on Medical Services held two meetings during this Association year 1981-82. Four committees make up the Council and are responsible for a broad range of subjects dealing with the delivery of medical care in Florida. The Council's recommendations are contained in the Board of Governors report. The following is a summary of the Council's major activities:

Committee on School Health

The Committee on School Health, chaired by Wesley S. Nock, M.D., serves as an advisory committee to the Department of Education and Health Program Office, Department of Health and Rehabilitative Services. The Committee held quarterly meetings and



Matters of Public Policy occupied the attention of Reference Committee II. Left to right: Charles A. Dunn, M.D.; Jerry D. Moore, M.D.; Ms. Julie Woodman, Recorder; Robert H. Hux, M.D., Chairman; Thomas R. Busard, M.D.; and John F. Lovejoy Jr., M.D.

made recommendations concerning school bus driver physical examinations, hearing screening, scoliosis screening, and funding for school health services.

Other subjects considered by the Committee included vision screening, handling school emergencies, measles control, and school entrance physical examinations.

Committee on Public Health

The Committee on Public Health, chaired by Patricia C. Cowdery, M.D., held two meetings and considered a broad range of important matters affecting public health which included a resolution for the elimination of measles during 1982, health problems created by the tremendous influx of refugees, and the funding problems associated with the state perinatal control center program.

The Committee also reviewed a large number of legislative proposals involving health issues and gave considerable attention to legislation that would adversely modify medical direction, funding and local input to county health departments.

Committee on Drug Abuse

The Committee on Drug Abuse, chaired by Robert P. Johnson, M.D., held two meetings and made recommendations concerning prescription forms, look-alike drugs, and a number of legislative proposals. The Committee also studied regulations involving private methadone clinics and the feasibility of a state-operated detox center for drug abuse patients. They have found that one of the most frequently abused drugs was a prescription drug called Dilaudid.

The Committee has submitted articles and statistics on drug abuse for publication in FMA communications. Presently, the Committee is working with drug abuse treatment programs in preparing a listing of treatment programs in Florida that could be considered for publication in *The Journal of the Florida Medical Association*.

Committee on Emergency Medical Services

The Committee on Emergency Medical Services, chaired by Roy M. Baker, M.D., is delighted to report the successful negotiation of an EMS contract between the Florida Medical Foundation and the Department of Health and Rehabilitative Services. This contract provides for medical direction to the state EMS office, the development of a five-year EMS plan for state EMS systems, and an analysis of Florida's critical care capabilities. The FMA's Committee on Emergency Medical Services has been designated as the steering committee for this project.

While the development of the EMS contract required several special meetings, the Committee also held two formal meetings to consider other matters, which included legislative proposals regarding the Sunset of Chapter 401, which is the statute regulating emergency medical services in the state, the establishment of an EMS trust fund for Florida, and designation of trauma centers.

Presently, the Committee is preparing for publication a summary report regarding the critical care survey conducted by the Committee during 1978-79.

Florida Medical Foundation Emergency Medical Services Project

The item in the Florida Medical Foundation Report on Emergency Medical Services Project was adopted. (See Report of the Florida Medical Foundation on page 583.)

RESOLUTION 82-19 Quantity on Prescription Label

Collier County Medical Society
Resolution 82-19 was adopted.

RESOLUTION 82-19 Quantity on Prescription Label

RESOLVED, That the FMA adopt as policy and seek assistance from the Florida Pharmacy Association in obtaining cooperation of all retail pharmacies in placing the quantity of the drug dispensed upon the prescription label.

The Chairman expressed his appreciation to all members of the association who provided guidance and counsel. Gratitude was extended to Dr. Joseph T. Ostroski, Chairman, Council on Medical Services, and Dr. Robert P. Johnson, Chairman, Committee on Drug Abuse, for their helpful comments and suggestions. Special thanks were conveyed to Dr. Samuel M. Day and Dr. Vincent P. Corso who represented the AMA Delegates at the meeting of the Reference Committee. Dr. Hux also expressed his sincere appreciation to the members of the committee and to FMA staff, Mr. Robert J. Harvey and Miss Julie Woodman for their assistance in the preparation of the report.

The motion of the Reference Committee that the Report of Reference Committee No. II be adopted as amended carried.



Eugene A. Stead Jr., M.D., Internationally known professor of medicine at Duke, seems to be making an important point to Eric Pfliffer, M.D., of Tampa. Both were speakers at the Seminar on the Process of Aging.

Report of Reference Committee No. III

Finance and Administration

Dr. William C. Hartley, Chairman, and his committee came forward to present the report of Reference Committee III, Finance and Administration.

Report C of the Board of Governors

The Reference Committee commended the Board for its outstanding performance during the year.

Remarks of the Speaker of the House

Dr. Hartley expressed his Committee's wishes that Dr. Perry be commended for the clear and precise rules under which the House of Delegates acts and for Dr. Perry's summary given at the beginning of the meeting.

The Remarks of the Speaker presented at the First House of Delegates were filed. (See page _____ First House of Delegates).

President's Address

Dr. Hartley expressed his Committee's wishes to commend Dr. Mullen for his aggressive leadership on behalf of the members of the Association for the past year.

The President's Address presented at the First Meeting of the House was filed. (See "President's Address," page 533.)

1981 House of Delegates Referrals Resolution 81-9

Installment Payment of Dues Recommendation C-1

Recommendation C-1 was not adopted.

Resolution 81-11 Seating of Alternate Delegates Recommendation C-2

Since Recommendation C-2 was for a bylaws amendment, and therefore required either approval of disapproval as submitted, the Reference Committee recommended that it be adopted. A substitute motion to refer Recommendation C-2 back to the Board for further study carried.



William C. Hartley, M.D. (standing) presided over Reference Committee III, which considered matters of Finance and Administration. Left to right: Alvin E. Smith, M.D.; Margaret C.S. Skinner, M.D.; Kay K. Hanley, M.D.; Dr. Hartley; Ms. Bonnie Taft, Recorder; Robert H. Threlkel, M.D.; David R. Arrowsmith, M.D.; and Ronald W. Case, M.D.



Past President T. Byron Thames, M.D. (left) and President Sanford A. Mullen, M.D., listen to discussion in the House of Delegates.

Resolution 81-14
FMA Defense of a Lawsuit Against
Various Insurance Intermediaries
Recommendation C-3

The Reference Committee recognized that the Board of Governors is charged with the responsibility of defending the policies of the House of Delegates and recommended the adoption of Recommendation C-3. Recommendation C-3, which recommended disapproval of Resolution 81-14, was adopted.

The Reference Committee further recommended: "That neither the House nor the Board of Governors take voluntary divisive action on the subject of specialty screens in the currently pending legal action filed by the Dade County Society of Internal Medicine." A motion to adopt the recommendation of the Reference Committee carried.

Professional Liability Insurance

Resolution 82-5
Professional Liability
Palm Beach County Medical Society

Resolution 82-9
Limit on Professional Liability Judgements
Dade County Medical Association

Resolution 82-22
PLI Reforms Legislation
Broward County Medical Association

Resolution 82-23
Professional Liability Insurance
Broward County Medical Association

Resolution 82-25
FMA Legislative Priorities
Dade County Medical Association

The Reference Committee had considered Report C of the Board of Governors (Professional Liability Insurance and the Ad Hoc Committee on Professional Liability) and Resolutions 82-5, 82-9, 82-22, 82-23, and 82-25 together, along with extensive and detailed testimony regarding the professional liability crisis in Florida. The urgency of the need for dramatic reforms, many of which are contained in the report and resolutions, had been repeatedly emphasized to the Committee. The testimony included reference to the urgent need for physicians and their families to participate in the political process during the 1982 political year. It was recognized that the problem extends to *all* Florida physicians, regardless of their insurance carrier or source of professional liability insurance. There had also been testimony regarding the need for a blue ribbon panel to be appointed by the Governor for the purpose of addressing the medical malpractice problem.

The Reference Committee recommended that the item on Professional Liability Insurance in Report C of the Board of Governors be adopted. It was adopted.

The Reference Committee chairman moved that Resolutions 82-5, 82-9, 82-22, 82-23 and 82-25 be referred to the Board of Governors in order that the principles contained in these resolutions be implemented immediately as part of the overall program of the Association, and that this issue be given the highest immediate priority. An amendment from the floor to alter the wording of the motion failed to carry. The motion of the Reference Committee carried.

The Reference Committee chairman moved that the House of Delegates take the position that all physicians continue their usual efforts in caring for their patients while the Association's Professional Liability Program is being carried out. The motion carried.

A motion that the House urge all physicians and their families during this critical year to participate to their fullest extent in the political process relative to the election of the members of the Florida legislature during 1982 carried.

Bylaws Amendment
Recommendation C-4

An amendment was moved by the Reference Committee to change the name of the student organization to "Florida Medical Association Student Medical Society." The motion to amend carried, and Recommendation C-4 was adopted as amended.

The Reference Committee noted with pleasure that Dr. Jean Jones Perdue of Miami was selected as

the recipient of the AMA Benjamin Rush, Award, and added its sincerest congratulations to, and commendation of, Dr. Perdue.

Report C of the Board of Governors was adopted as amended.

Report C of the Board of Governors Sanford A. Mullen, M.D., Chairman

Your Chairman is pleased to submit this report to the House of Delegates regarding the activities of the Board of Governors during the past year, and also the activities of the Association's Council and Committees.

Your Board and the many physicians who have given freely of their time on behalf of the Association, have exercised every effort to insure the highest level of medical care for the citizens of Florida and the preservation of our free enterprise system of health care delivery.

This report reflects the high level and broad scope of programs and activities in which the Association is currently involved, both as a result of pursuit of the goals and priorities of the Association, as well as the many crucial issues which continue to emerge and which affect physicians individually and collectively.

Your Chairman is grateful for having had the opportunity of serving this fine organization during the past year and it has been a particular pleasure to work with the high caliber of physicians who have served on the Board and in other capacities in behalf of the Association. Each of them has represented his fellow physicians unselfishly and to the best of his ability, and with the best interest of his colleagues always uppermost in his mind.

Robert E. Windom, M.D., President-Elect
Gerold L. Schiebler, M.D., Vice President
Luis M. Perez, M.D., Secretary
J. Russell Forlaw, M.D., Treasurer
T. Byron Thames, M.D., Immediate Past President — 1983
Richard S. Hodes, M.D., Past President — 1982
Francis C. Coleman, M.D., At Large — 1982
J. Lee Dockery, M.D., District A — 1982
Thomas E. McKell, M.D., District B — 1983
Dick L. Van Eldik, M.D., District C — 1985
Norman M. Kenyon, M.D., District D — 1984
James B. Perry, M.D., Speaker of the House
Rufus K. Broadaway, M.D., AMA Delegate — 1982
Eugene G. Peek Jr., M.D., HRS — 1982
Vernon B. Astler, M.D., FPIR — 1982
Robert N. Webster, M.D., SBME — 1982
Mr. James E. Deming, Student Member — 1982

To my successor, Dr. Bob Windom, I extend my best wishes for the same rewarding experience that I have enjoyed in serving the FMA and I pledge to him my fullest support in facing the crucial issues that affect all physicians.

Major Activities

1982 Annual Meeting — The Board approved the format for the 1982 Annual Meeting with "The Process of Aging" as the scientific theme.

FMA Leadership Conference — A single subject, Health Care Financing, was the theme for FMA's 1981 Leadership Conference at Lake Buena Vista with nationally noted speakers from all parts of the country taking part. Input, trends and projections

for the future in this vital area, including the viewpoints of state and federal governments, practicing physicians, the consumer and business were heard. Over 200 people, including 187 members of the Florida Medical Association, took part during the program, Saturday and Sunday, January 30-31. This represented 29 county medical societies and 13 FMA-recognized specialty groups. President Sanford A. Mullen, M.D., and President-Elect Robert E. Windom, M.D., presided at the session. Speakers included: Eli Ginzberg, Ph.D., Director, Conservation of Human Resources, Columbia University, New York City; Gary J. Clarke, J.D., Assistant Secretary for Health Planning, Department of Health and Rehabilitative Services, Tallahassee; Mr. Samuel J. Tibbitts, a founder and Co-Chairman of the National Voluntary Effort, Los Angeles, Calif.; James S. Todd, M.D., Vice President of the Physicians' Insurance Association of America, Ridgewood, N.J.; Vernon B. Astler, M.D., Chairman of the Board of the Florida Physicians' Insurance Reciprocal, Boynton Beach; U.S. Sen. Dave Durenberger of Minnesota; State Rep. Richard S. Hodes, M.D., Tampa; Charles P. Hayes Jr., M.D., Chairman of the FMA Council on Health Care Financing, Jacksonville; Mr. Stephen A. Doiron, President and Chief Executive Officer, Caribbean Atlantic Resource Enterprises, Inc., Boca Raton; Mr. Roy Pfautch, President of Civic Service, Inc., St. Louis, Mo.; Edward N. Brandt Jr., M.D., Assistant Secretary for Health, Department of Health and Human Services, Washington, D.C.; Mr. Robert A. Carpenter, Manager of Health Care Cost Containment, Republic Steel Corp., Cleveland, Ohio; Miss Bess Myerson, consumer advocate and former Miss America, New York City; and James H. Sammons, M.D., Executive Vice President of the American Medical Association, Chicago, Ill.

Various approaches were taken by the distinguished panel, but there was agreement that health care costs must be brought under control and industry, patients, providers and government all must cooperate if there is to be any successful braking. The March issue of *The Journal of the Florida Medical Association, Inc.* was devoted to the papers presented at the Conference.

Several broad principles were presented by the speakers at the Conference:

1. The decade of the 1980s and 1990s will make a major impact on the delivery of health services. Many changes are anticipated. The entire subject is extremely complex.
2. Doctors of medicine are still highly regarded by the people of the United States. Doctors and clergymen are the two most respected professions and usually alternate between first and second place on various polls. Other ranked professions are far below the two leaders.
3. In general the public likes the quality of medical care but is becoming concerned about the cost of medical care although they do not believe that the doctors are responsible for the increase in cost.
4. There is a great desire by most people to retain a close and personal doctor-patient relationship.
5. The problem of increasing cost in health care is a broad-based social problem involving all parts of society, not just doctors and hospitals.
6. Doctors must be heavily involved in developing solutions to the problems relative to the increasing costs of health care.
7. Doctors must be willing to provide effective peer review and work actively to remove the small number of incompetent and venal physicians who are in practice.
8. Most thoughtful consumers and leaders from business, industry, labor, health insurance and hospitals want to work with doctors in helping to solve the problem of increasing health care costs.
9. There is going to be a change in financial rewards for doctors as the increased number of doctors enter practice in the next decade. This may well result in reduction of the incomes of most doctors but the compensation for this will be in the improvement of lifestyle with a better opportunity for doctors to be more involved with their families and communities.

The conference has made it abundantly clear that it is essential for doctors to become an active part of the groups at the local level which are beginning to make decisions as to the way health care will be delivered in the future. Local community leaders in most instances want doctors to be active participants. Doctors have the responsibility to protect the quality of care and make certain the quality is never compromised in the rush to save dollars.

FMA Legislative Workshop — A special day-long program was held on October 24 at Tampa to discuss in depth the Association's legislative priorities for 1982. The session began on January 17, three months earlier than usual due to reapportionment. The program was designed for county medical society officers, executive directors, legislative chairmen, FMA Auxiliary officers and legislative representatives and key contact physicians. In addition, all FMA members were invited to attend. A detailed report on the Association's legislative activities during the session is included in another section of the *Delegates Handbook*.

The Florida Physicians' Insurance Reciprocal — An annual report of finances and other pertinent information on the FPIR for the year ending December 31, 1981, was mailed to the entire FMA membership in March and will be included in the *Delegates Packet*. This report reflects the current financial status of the FPIR, levels of coverage, claims activity, investment information and other corporate information. The following is a summary of the highlights of the report:

Board of Directors and Officers

The Board is composed of five subscriber physician advisors serving on a staggered-term basis. They select their successors or additions subject to approval of the Board of Governors of the Florida Medical Association, Inc. The current members are:

Vernon B. Astler, M.D.
Chairman, Delray Beach, 1986
(Past President, FMA)

Richard S. Hodes, M.D.
Treasurer, Tampa, 1984
(Past President, FMA)

Jack A. MacCris, M.D.
Vice Chairman, St. Petersburg, 1985
(Past President, FMA)

T. Byron Thames, M.D.
Orlando, 1982
(Past President, FMA)

O. William Davenport, M.D.
Secretary, Miami, 1983
(Past President, FMA)

W. Harold Parham, D.H.A., EVP of FMA, serves as Attorney-in-Fact and President.

Physician Participation — The Reciprocal has continued to grow, with a current enrollment in excess of 6,700 physicians in the program.

Underwriting — The Reciprocal contracts with the Florida Medical Association, Inc., and its component county medical societies to review and advise regarding physicians meeting underwriting standards of the Reciprocal.

Policy Coverage — During 1981, the Reciprocal provided insurance coverage for over 6,700 physicians with \$3,360,500,000 of primary coverage (\$500,000 limit); \$1,758,500,000 for \$500,000 in excess of the primary coverage; and \$601,500,000 for \$500,000 in excess of \$1,000,000 for a total insurance in force of \$5,720,500,000 (\$5½ billion dollars).

Trends — PLI loss experience continues to follow a serious trend. The severity of claims is escalating and in 1981 there were new claims of approximately \$15,000,000 but for the previous years there were almost \$12,000,000 in additional claims. This obviously exceeded the amount of funds that were collected for losses.

The Reciprocal Board has considered the options available to it in facing the serious liability trends alluded to above and has remained committed to a policy of fiscal and actuarial soundness in determining premium structure.

The FPIR Board members participate actively, and carefully evaluate all serious claims, underwriting policy, and investment guidelines and will continue to pursue the following priorities:

1. An intensive malpractice prevention program in cooperation with the Florida Medical Association's county medical societies, specialty groups, annual meetings, and Florida hospital staff meetings emphasizing good personal relations, logical informed consent, accurate legible records, and diligent medical care at affordable prices, as well as specific points in claims prevention; (physicians who have not participated will be surcharged in 1983);
2. Aggressive investment policy;
3. Emphasis placed upon the claims handling, particularly of small claims, in an effort for them to be disposed of more expeditiously and efficiently; and
4. A greater emphasis placed upon medical peer assistance to physicians in defense of their suits.

1981 House of Delegates Referrals

The Board reviewed the proceedings of the House of Delegates and items requiring additional study and/or action were referred to the appropriate Councils and Committees. Some matters required Board action only. Individual actions regarding the policies of the House of Delegates appear in the various Council and Committee reports as well as in this and other reports of the Board of Governors in the *Delegates Handbook*.

Resolution 81-9 — Installment Payment of Dues — This resolution introduced by the Broward County Medical Association was not adopted but referred to the Board of Governors. The Resolved of the resolution called for a study of the possibility of installment payment of dues throughout the year.

The Board of Governors, at its meeting in June, referred this matter to the FMA Secretary and Treasurer for review and recommendations. The Board subsequently received an in-depth report on the activities that had been carried out in considering the feasibility of implementing an installment dues payment provision in Florida including a summary of the findings of an investigation of other state medical associations which have some type of installment dues provision or which allow the use of credit cards (a copy of the report will be included in the *Delegates Packet*).

RECOMMENDATION NO. C-1

Recommendation not adopted.

Resolution 81-5 — Physicians' Assistants — This resolution was not adopted but referred to the Board of Governors for further consideration.

RESOLUTION 81-5

RESOLVED, That the Board of Medical Examiners limit all new Physicians' Assistants certificates to be used in low physician density areas, thus providing increased health care delivery in rural areas and simultaneously decrease their cost effectiveness in urban areas; and be it further

RESOLVED, That physicians who employ a Physicians' Assistant must be present on the premises when the Physicians' Assistants are involved in patient care; and be it further

RESOLVED, That the employing physician should actively and properly identify the Physicians' Assistant; and be it further

RESOLVED, That there should be no presigned prescriptions available; and be it further

RESOLVED, That patients requiring referral should be examined by the employer physician prior to referral.

The Board of Governors referred this matter to the Council on Legislation for review with input as necessary from Dr. Robert Webster as the SBME representative on the Board of Governors and from the Council on Specialty Medicine. In reviewing the resolution, it was pointed out that presigned prescriptions are prohibited by law. The Florida Academy of Family Physicians, which serves as the liaison with the Physicians' Assistants, has been requested to attempt to work with that group in resolving the concerns expressed in the resolution.

Resolution 81-11 — Seating of Delegates — This resolution introduced by the Hillsborough County Medical Association, was adopted by the House of Delegates and referred to the Board of Governors for an appropriate amendment to the FMA bylaws to carry out the intent of the resolution. The Resolved of the resolution called for a provision patterned after that of the American Medical Association bylaws to provide for the flexible interchange of Delegates and Alternates to participate in the meetings and sessions of the House of Delegates with full privilege.

RECOMMENDATION NO. C-2

Recommendation not adopted—Referred to Board of Governors

THAT THE HOUSE OF DELEGATES ADOPT THE FOLLOWING AMENDMENT TO THE FMA BYLAWS WHICH PROVIDES FOR THE SEATING OF ALTERNATE DELEGATES DURING SESSIONS OF THE HOUSE OF DELEGATES:

CHAPTER IV — HOUSE OF DELEGATES

Section 11. TENURE OF DELEGATES

~~A delegate who has been officially seated at a meeting of the House of Delegates shall remain a delegate of the component society which he represents throughout all sessions of that meeting, and his place shall not be taken by any other delegate or alternate.~~

Each delegate seated at an Annual Meeting shall serve until the next Annual Meeting, and shall serve at all interim or called meetings between Annual Meetings, unless the component society by certification of its president or secretary duly designates a different delegate.

Section 12. ALTERNATE DELEGATES

Each component society shall select alternate delegates corresponding in number to the delegates to which it is entitled, and shall designate to the secretary of the association the order in which they are to serve.

Each alternate not seated as a delegate at the Annual Meeting shall continue to serve as an alternate until the next Annual Meeting and for all interim or called meetings between Annual Meetings, unless the component society by certification of its president or secretary duly designates a different alternate.

When a delegate is unable to attend an Annual Meeting or any session of the House of Delegates, his/her designated alternate may

be seated provided that the alternate delegate shall deposit with the Credentials Committee a certificate signed by the president or secretary of the component society stating that the alternate has been properly selected to serve, provided further that one designated delegate or alternate can be seated at any Annual or Special Meeting of the House of Delegates.

----- deleted language

_____ new language

Resolution 81-14 — FMA Defense of a Lawsuit Against Various Insurance Intermediaries — This resolution introduced by the Dade County Medical Association, was not adopted. The Resolved of the resolution called for the FMA to utilize every available means to refrain from defending the lawsuit filed by the Dade County Society of Internal Medicine against various insurance intermediaries and that FMA refrain from spending Association funds in defense of this lawsuit. The House voted to refer the resolution to the Board of Governors with the request that the Board reconsider its previous decision concerning participation in the lawsuit referred to in this resolution. In its report to the House of Delegates in 1981, the Board reported on an action regarding dual fee schedules. The Board reaffirmed the current FMA position of opposition to the application of Specialty Screens (Dual Fee Schedules) in Florida and also directed that FMA, if invited, participate in the defense of the lawsuit filed by the Dade County Society of Internal Medicine against Blue Cross/Blue Shield of Florida, GHI and the Department of HHS, and that FMA's participation would be for the purpose of defending the position which has been adopted and reaffirmed by the FMA House of Delegates in opposition to specialty screens.

Pursuant to the actions of the House in 1981, the Board reconsidered its previous action and adopted the following policy statement regarding this issue:

The Board of Governors is of the opinion that it is the Dade County Society of Internal Medicine that has violated the policies and intent of the House of Delegates of the FMA, and the Board of Governors not only had a right but also has a responsibility to defend the policies of the House of Delegates when requested to do so whether it be in public, before the legislature, or in the courts.



Incoming President and Mrs. Robert E. Windom, M.D., pause for a moment for a picture taking session with their three sons. Left to right: Hugh Windom; Ross Windom; Mrs. Windom; Dr. Windom and Robert Windom.

RECOMMENDATION NO. C-3

THAT THE HOUSE OF DELEGATES APPROVE THE BOARD OF GOVERNORS' ACTIONS IN REAFFIRMING FMA POLICY IN OPPOSITION TO THE APPLICATION OF SPECIALTY SCREENS IN FLORIDA AND THAT RESOLUTION 81-14 NOT BE ADOPTED.

Resolution 81-3 — Physician Charges for Laboratory Services — (See Board Report E, Reference Committee V).

Resolution 81-5 — Physicians' Assistants — (See Board Report A, Reference Committee II).

Resolution 81-10 — Discriminatory Reimbursement by Medicare — (See Board Report E, Reference Committee V).

Finance — The Association had an income during 1981 from all sources of \$2,510,218 and total expenditures during the year of \$2,376,962, for a gross gain of \$133,256. The figures do not reflect expenditures for equipment or depreciable items as they are a transfer from liquid to fixed assets. The net worth of the Association as of December 31, 1981 was \$2,931,686.

In 1976, the FMA implemented a special assessment to be restricted for the purpose of public relations and legislative activities. Interest of \$24,799 was earned on these funds in 1981 and there were no expenditures. The balance of the special assessment funds as of December 31, 1981 was \$196,893.

The House of Delegates in 1980 authorized the Board of Governors to establish a special trust fund for the current and future reserves of the Association, the initial funding coming from the approximately \$600,000 profit from the sale of the headquarters building in Jacksonville. The Trustees of this fund are the three (3) immediate living past presidents of the Association, including the immediate past president who is an officer. The principal and interest of these funds accrue in this trust account which shall be established in the name of the Association in an escrow trust. The Trustees may release the funds upon request of the Board of Governors which indicates that an emergency exists which cannot be financed through regular income or assets of the Association. In the event the Trustees do not agree to release the funds, the Board of Governors may direct their release upon $\frac{3}{4}$ vote of the active members of the Board of Governors.

The net proceeds from the sale of the FMA property at 801 Riverside Avenue and the purchase of 760 Riverside Avenue left a net of \$137,000 and, as directed by the Board, was placed in the reserve fund.

The first annual principal payment on the mortgage held by the FMA on the 801 property in 1981 of \$61,257.32 was placed in this trust fund. The interest earned through December 31, 1981 in the fund was \$23,679.06 and the total balance in the trust fund as of December 31, 1981 was \$221,936.38.

The Board reviewed the financial statements and proposed 1982 budget presented by the Treasurer, Executive Vice President and Executive Director. The Board approved the proposed budget for 1982 for the total anticipated income from all sources and expenditures in the amount of \$3,097,000. It was noted that approximately 50 percent of the anticipated additional income resulting from the increase of FMA dues effective January 1, 1982, was budgeted to reserves. It was also noted that in keeping with the policy established by the House of Delegates, that \$50.00 of each member's dues was budgeted to public relations and legislative activities.

The audit conducted by the Association's CPA firm of Harbeson, Beckerleg and Fletcher for the year ending December 31, 1981, is available for inspection by any member of the Association who may wish to review it.

Management — In concurrence with the EVP's request to be relieved of management responsibilities following the 1984

Annual Meeting, the Board appointed a special Committee on Management in May 1980 to study and make recommendations regarding the philosophy to be approached by the Association regarding the position of the EVP (Chief Administrative Officer) and the transition period. The Committee is composed of Vernon B. Astler, M.D., Past-President and Chairman; James B. Perry, M.D., Speaker of the House; and T. Byron Thames, M.D., Immediate Past President; and the current President, Sanford A. Mullen, M.D.

The Board approved and reported to the House of Delegates at its meeting in 1981 major reorganization of FMA senior staff responsibilities to provide:

- That the EVP, Dr. Parham, continue to transfer the majority of his FMA responsibilities to the Executive Director and Associate Executive Director until prior to his retirement from the FMA, he retains only financial and policy responsibilities and no operational responsibilities, and that the Executive Director be trained in these areas also.
- That FMA take advantage of Dr. Parham's proven management and financial ability and that upon retirement, he be retained as a consultant for finance and policy to the Board of Governors through the Executive Committee for a minimum period of five years.
- That the Management Committee be continued through the management transitional period, report to the Board at least annually regarding the progress, additional recommendations; and that the current President and President-Elect of the FMA serve on the Committee during their term of office.

The Board is pleased to report that the transition of the management of the FMA to date has been most satisfactory. This has been concurred in by both the Immediate Past President, Dr. Thames and the current President, Dr. Mullen. At its meeting in January 1982, the Board approved the designation of Donald C. Jones, Executive Director, as Chief Executive Officer of FMA effective January 16, 1982. Dr. Parham will continue his responsibilities as Executive Vice President for policy implementation and finance, which he plans to terminate in early 1984, except in a consultant capacity. Mr. Scotty Fraser was named Associate Executive Director. Mr. John Thrasher will continue as FMA Legal Counsel and serve as a consultant for Legislative Affairs. He will also continue his fiduciary responsibilities as Assistant Treasurer of FLAMPAC.

Status of Litigations and Investigations

1. Davidson, Coria v. FMA, PIMCO, FPIR

This protracted litigation involving two Key West physicians alleging that they were improperly terminated by the Florida Physicians' Insurance Reciprocal in a conspiracy with PIMCO and FMA was recently adjudicated by a Circuit Judge in Miami on the basis of FMA's Motion For Summary Judgment. The Court entered a Summary Judgment in favor of FMA, PIMCO and FPIR on the basis that the statute which the plaintiffs' were basing their underlying cause of action was inapplicable on the basis that the statute was not intended to create a right of a private cause of action, but was designed to provide relief through the administrative processes of the Department of Insurance. This matter has been appealed by the two plaintiff physicians to the Third District Court of Appeal in Miami. At this point in time we feel confident of successfully concluding this matter.

2. Florida Optometric Association, et al v. Department of Professional Regulation and Board of Pharmacy:

In March of 1981 the Florida Optometric Association filed a suit for Declaratory Judgment and Injunctive Relief seeking the right under existing law to prescribe, use and dispense non-controlled prescription drugs. The Board of Governors, has previously authorized the FMA to actively support the position of the Florida Society of Ophthalmology in its efforts to intervene in this lawsuit. After some initial legal issues were raised as to the jurisdiction of the trial judge to hear this particular case, which have now been resolved, nothing significant has transpired. None of the parties apparently want to move the case along at this time and it appears to some observers that the case was filed by the Florida Optometric Association to prevent an adverse Attorney General's opinion on this issue. We are continuing to work with the attorneys for the Florida Society of Ophthalmology and to monitor this case closely.

In addition to this legal action, the optometrists have attempted to petition the Board of Optometry to adopt a rule that would essentially allow them to do the same thing that they are seeking by way of the lawsuit. The Board of Governors has also authorized us to involve ourselves in this matter to the extent we can and at the appropriate time.

3. **Sarasota County Public Hospital Board v. Shahawy, M.D.:**

In this case the FMA Board of Governors authorized entry in this appellate procedure as an amicus curiae in support of the Sarasota Public Hospital Board and the Florida Hospital Association. A decision of a lower court in this case essentially misconstrued a section of the Florida Statutes with respect to granting of clinical privileges. Permission by the Second District Court of Appeal was granted allowing us to file an amicus brief in this case. On December 23, 1981 the Second District Court of Appeal rendered an opinion reversing the lower court and supporting our view in this case. It was the view of the appellate court that the hospital board's and medical staffs that establish criteria for the admission to the medical staff on the basis of furthering the goal of providing high quality patient care will not find that criteria to be judicially inappropriate, provided it is not exercised in an unreasonably arbitrary or capricious manner. In summary, it would therefore appear that the opinion of the court in this case may be of considerable help to governing boards of hospitals and to the medical staff committees who are endeavoring to do a conscientious job in evaluating medical staff credentials.

4. **Workers' Compensation Fee Schedule:**

A request for an increase in the Workers' Compensation Fee Schedule beginning in January of 1982 was presented to the new statutorily created panel by Chairman of the FMA Workers' Compensation Committee, Dr. Jim Richards. A decision was ultimately made by the committee to recommend to the Department of Labor that the fee schedule be increased to the 66 2/3 percentile of actual charges. This is now being implemented by rule of the Department.

Board Actions of Major Importance

FMA Priorities 1981-82 — The Board adopted the following Association priorities for 1981-82 and directed that the Association's staff and resources be utilized to carry out these priorities:

Membership:

- Continued efforts to improve communication with the FMA membership directly and through respective county medical and specialty societies.
- Membership development at the county, state and national levels to include medical student and house staff representation.

- Continued development of the statewide Impaired Physician Program (through the Florida Medical Foundation).
- Continued efforts to encourage FMA members to acknowledge their individual responsibilities for becoming actively involved in public affairs, legislation and political action activities including participation in FLAMPAC and in local key contact physician programs.

Public:

- Provide government bodies, news media, and the public with timely, and responsive Association views on:
 1. Standards of health care;
 2. Health care delivery mechanisms;
 3. The role of government in health care delivery;
 4. Cost of medical care;
 5. Preventive health care educational programs.
- Explore and promote health care cost effectiveness through:
 1. Joint programs with business and industry to provide cost efficient health care within the existing private health care delivery system.
 2. Actively advocate physician participation in health care cost coalitions with business and industry.
 3. Continued support for the "Voluntary Effort" cost containment movement.
- Encourage physician involvement in community affairs programs.
- Explore every feasible resolution to the problem of availability and cost of professional liability insurance for Florida physicians.

Programs:

1. Continued refinement of the FMA Council and Committee structure and scope of activities to best serve the interest of the membership.
2. Implementation of a program for corporate visitations in the development of health care cost coalitions with business and industry.
3. Continuation of FMA medical service programs with emphasis on substance abuse, emergency medical services, school health and public health.
4. Development of a closer working relationship with the Department of HRS.
5. Continued emphasis on local support for legislative activities and development of active political education programs in cooperation with the FMA Auxiliary in each community.
6. Continued support of the FMA Auxiliary's educational programs and activities, including expanded support of FMA Auxiliary activities at the national level.
7. Educational programs and activities on health care for the aging.
8. Continued emphasis on a statewide PMUR program, conducted by the private sector, as a viable alternative to a Federal Government controlled program whose emphasis is solely on cost without regard to quality.
9. Active participation by physicians in cost awareness programs at all levels including physicians in active practice, physicians in training and medical students.

American Medical Association (AMA):

1. Membership development.
2. Cooperative effort to coordinate programs and activities at all levels of the Federation.

Issues:

1. Cost of Medical Care.
2. Continued monitoring of the effectiveness of the Department of HRS as it pertains to the public's health and continued strong support for ensuring effective medical physicians' leadership at all levels of the Department.
3. Opposition to any compulsory comprehensive national health insurance program.
4. Support enactment of national legislation to accomplish changes in the future direction of Federal Government programs, including:
 - Repeal of P.L. 93-641 and the elimination of HSA's with future appropriate health planning activities to be carried out by state and local governments.
 - The elimination of professional standards review organizations with support for peer medical utilization review (PRO) to be carried out at the local level within the private sector.
 - The elimination of federal subsidies for the unfair promotion of HMO's as a more economical alternative to other private health care delivery mechanisms.
5. Professional liability.
6. Opposition to encroachment on the practice of medicine by non-M.D. health care providers.
7. 1982 Sunset Review of Florida Statutes directly affecting the medical profession.

Membership — Efforts have continued to enhance communications with FMA component county medical societies, the FMA membership at large, recognized specialty groups and other related organizations. These activities are reflected throughout the *Delegates Handbook* in the annual reports of FMA Councils and Committees including the public relations office and the FMA Speakers Bureau. The Board continued the policy of rotating meetings of the Board to different areas of the state and that invitations to attend be extended to the presidents of surrounding county medical societies and their executive directors if they desire. In addition, county medical society executive directors are invited to attend the FMA Executive staff meetings held immediately after each Board meeting to be advised of actions taken by the Board.

One of the major activities carried out during the year to enhance communications with the membership, has been the FMA visitation program. FMA President, Dr. Mullen, has endeavored to visit as many county medical societies as possible during his tenure as president. During the year he visited the majority of FMA's component societies. He has also visited with a number of FMA's recognized specialty groups and other allied organizations.

Communications have been carried out through the various Association publications and newsletters including the FMA Journal. The *Board Summary* which summarizes the major actions of the Board has been published in the FMA Journal for the benefit of the membership. The *President's Memo* has been utilized to relate single issues of prominent concern or interest. The *FMA Briefs* have included a broad range of topics relating to medicine; and the *FMA Gray Paper*, which is primarily directed to county medical societies, has been used to relate issues of timely importance.

Membership development at all levels has been a major priority during the year with special emphasis on AMA membership.

The Board of Governors, at its meeting in January 1981, in reviewing the report of the Florida Delegation to the AMA on the actions of the AMA House of Delegates at the December 1980 Interim Meeting, noted the growing concern with declining AMA membership (it has dropped well below 50 percent of the physician

population in the U.S.). The Board expressed the feeling that every possible effort should be made to increase the AMA membership in Florida. At its meeting in March, the Board reviewed a report advising that Florida had come within 34 members of qualifying for an 8th delegate. At that time it was directed that a membership report be prepared and presented to the Board at each meeting. At its meeting in June 1981, the Board adopted membership development as one of the Association's major priorities for 1981-82, and requested that the Secretary and Chairman of the AMA Delegation review this problem and submit recommendations to the Board at its fall meeting for a membership development program.

In carrying out the Board's directives, the FMA Secretary and AMA Delegation Chairman, along with other FMA representatives, participated in an AMA-sponsored membership development program in Washington in August and, in addition, met with FMA staff to develop recommendations to the Board.

Observations

1. The strength of numbers which enables organized medicine at all levels to present a unified voice is imperative for effectively meeting the crucial issues facing the practice of medicine.
2. While it is recognized that increasing the AMA membership is of vital importance, it is equally important that efforts be made to increase physician participation at county and state levels.
3. While the FMA has experienced some periods of rapid acceleration in its membership growth and other periods of minimal growth, membership statistics indicate that the FMA has enjoyed an overall stable membership development. This growth has averaged 6 percent over the past 5 years. The FMA has not experienced a severe membership retention problem to date. However, it has not been determined what the effect would be on FMA membership if state membership were not mandatory. Also, in certain areas of the state, particularly south Florida, there is a growing number of physicians who remain outside the stream of organized medicine.
4. The economic impact of continuing increases in organizational dues will have an ultimate effect on the physicians' ability to participate in the many levels and activities of organized medicine, including AMA, state and county medical societies, state and national specialty societies, PAC, etc.

The Board approved recommendations for membership development in Florida including:

- A standing committee of the Board of Governors be appointed to be composed of the FMA Secretary, Chairman of the AMA Delegation and Representatives from each of the four Florida Medical Districts and that this committee be charged with the responsibility of on-going membership development and retention at all levels; and further that the committee carry out its functions in close cooperation with FMA component county medical societies and the AMA.
- That following the initial billing for dues payable on January 1, that on March 1 AMA dues statements be sent to all physicians who have paid their county and state dues, but who have not paid their AMA dues, along with a promotional message. That an additional promotional message and statement be sent to those physicians who have not paid by June 1.
- That periodic articles be published in *The Journal of the FMA* regarding AMA membership, as well as state and county medical society membership. The Board noted that in cooperation with the editor of *The Journal* the November cover of *The Journal* was dedicated to AMA membership. In addition, county medical societies were being urged to include articles on membership in the November or December issues of their county society bulletins.
- That consideration be given to the feasibility of unified membership in Florida.

- That a study be authorized to determine as accurately as possible the total number of physicians in private practice in Florida who do not belong to their county medical societies in order to determine if it would be feasible to attempt to bring these physicians into organized medicine.
- Requested that FMA component county medical societies make every effort to insure that physicians elected to serve in the FMA House of Delegates are members of the AMA.

The Board was pleased that due to an increase in the membership in Florida during 1981, the FMA will gain an additional delegate for 1982, bringing the total number of Florida delegates to eight. Election of the eighth delegate and alternate will be held at the FMA Annual Meeting in May and they will serve beginning with the AMA meeting, June 13-17, 1982. The two-year term will be retroactive to January 1, 1982, expiring December 31, 1983.

Public:

The reports of several Councils and Public Relations Office and FLAMPAC outline a broad scope of programs and activities that have been carried out to encourage individual physician participation in the many important activities of organized medicine and the political process; providing the public, government bodies and the news media with a broad range of issues relating to health care delivery. Major emphasis has been placed on efforts to control the escalating cost of medical care through cooperative dialogue with local business and industry.

Physician involvement in community affairs has been President Mullen's theme during the past year and he has carried that message to physicians across the state in his many visits with local county medical societies and in other forums in which he has participated.

Resolution of the professional liability insurance problem is included as a separate item in another section of the Board's report.

Programs:

FMA programs have exemplified the fullest commitment to quality of health care. Major achievements have been in implementation of an Emergency Medical Services project in cooperation with the Department of Health and Rehabilitative Services, significant physician participation in health care cost initiatives, and exemplary contributions by the FMA Auxiliary in support of the Association's programs and activities. A genuine concern with the senior citizens of Florida has been reflected in the selection of the Process of Aging as the subject of a special issue of the FMA Journal as well as the scientific theme of the 1982 FMA Annual Meeting. The FMA has contributed to pursue a cooperative working relationship with the Department of HRS. The success of this effort during the past year was in large part due to the spirit of cooperation that has been extended to FMA representatives by HRS Secretary, Mr. Dave Pengree, and Deputy Secretary, Dr. James Howell.

Issues:

Professional Liability National Health Insurance, Health Systems Agencies, PSRO, unfair promotion of alternative systems of health care delivery and the encroachment on the practice of medicine by non-M.D. health care providers, remain in the forefront as issues of utmost concern to physicians and to which the Association devotes a major portion of its resources and staff support.

Professional Liability Insurance:

Resolution of professional liability insurance problems remains as one of the Association's top priorities. The Board, at its

meeting held in conjunction with the 1981 Annual Meeting, approved establishment of a special Ad Hoc Committee of the Board on Professional Liability. This committee, which is comprised of T. Byron Thames, M.D., Chairman; Vernon B. Astler, M.D. and Francis C. Coleman, M.D., conducted a comprehensive and in-depth study of this crucial issue.

The Board reviewed the report and recommendations of the committee and approved the report in principle for implementation as feasible. The Board further requested that the entire report be published in the November issue of the FMA Journal. (Included as Enclosure #1 to the *Delegates Handbook*).

The Board has reviewed the activities of the Florida Physicians' Insurance Reciprocal and its management agent, Professional Insurance Management Company (PIMCO). The Board commended the representatives of the Florida Physicians' Insurance Reciprocal (FPIR) and the Professional Insurance Management Company (PIMCO) for the excellent risk management programs that have been conducted in county medical societies throughout the state.

Mandatory Coverage for Hospital Staff Privileges:

The Board reaffirmed FMA policy of opposition to mandatory malpractice insurance for hospital staff privileges and reiterated policy adopted by the House of Delegates that:

"The Florida Medical Association questions the advisability of a defensive requirement of some Florida hospitals that each physician carry a specific amount of personal professional liability insurance as a prerequisite to hospital staff privileges and believes this to be an unnecessary requirement imposed on physicians.

"The FMA further reaffirms its belief that such a requirement for hospital privileges may actually encourage, rather than discourage, the proliferation of unwarranted legal actions against both physicians and hospitals.

"The FMA is confident that such a requirement in no way insures quality care to the public but rather, may actually work to the disadvantage of the patient by imposing such financial constraints on some types of physicians so as to exclude them from hospital practice.

"It is the opinion of the FMA that the primary consideration for hospital medical staff appointments should be based on professional qualifications of the individual physician."



Vice Speaker Franklin B. McKechnie, M.D., presides over the House of Delegates during the presentation of a Reference Committee report.

Malpractice Screening Boards:

The Board expressed support in principle for the concept of professional malpractice screening boards and authorized the FMA PLI Committee to pursue further development of the proposal.

Florida Patients' Compensation Fund:

The Board reviewed a report that the Florida Patient's Compensation Fund is short of funds to settle claims. The first assessment of \$1,350,672 for year 1978 had not been billed before a request was made and approved of \$13,935,927 for year 1979. According to information from John W. Odem, FPCF General Manager, their latest actuary study shows the fund to need \$177 million to pay claims incurred through year 1981. With income projected at \$55 million, this is a shortfall of \$122 million that will come through assessments, the first two having just been made. Physicians will be assessed 100% of their 1979 original fee, approximately \$2,400,000 and hospitals will pay up to 204% of their original fee, approximately \$11,480,000 assessment for year 1979. There appears to be many more assessments in the works. In order to get income in line for future years, the FPCF Actuary has suggested a rate increase effective year 1982-83 over year 1981-82, of 241% for Class 1 and 2 physicians, 255% for Class 3 physicians and hospital rates would increase 130% per bed. A Class 3 physician in Dade or Broward would increase from \$4,323 to \$11,022 for excess over \$100,000. Additional assessments plus future rate increases appear to be imminent.

Impaired Physician Program — The Board of Governors, in keeping with the actions of the House of Delegates, has continued to support development of the FMA Impaired Physician Program. The Board has provided funding for administering the program and is currently investigating additional sources of funding for further development of the program, particularly from the Board of Medical Examiners. The Board has reviewed the activities of the Impaired Physicians Committee during the past year and wishes to commend Dr. Guy Selander and his entire Committee for their dedicated interest and efforts in aiding their fellow physicians through this important program.

House of Delegates Ratio — The Board authorized that the current allocation of delegates remain at one delegate for every fifty active members or fraction thereof for the 1982 Annual Meeting.

Alternate Annual Meeting Location — In response to the desire expressed by the House of Delegates, the Board has continued to monitor the development of hotel facilities in the central Florida area that adequately satisfy the extensive and diverse requirement for the FMA Annual Meeting. As a result of the current development of EPCOT at Walt Disney World, there is currently a significant expansion of hotel facilities in the surrounding area particularly in Lake Buena Vista where a major high-rise, 900-room hotel with multiple meeting rooms and exhibit space is under construction. The property will be known as the Palace Hotel and is being developed by the owner of the Royal Plaza Hotel which is also located in Lake Buena Vista. It is anticipated that construction on the property will be completed in early 1983 but possibly not in sufficient time to contemplate it as the site for the 1983 Annual Meeting.

The Board has therefore directed that the Palace Hotel in Lake Buena Vista be selected as the site for the 1984 Annual Meeting, May 2-6, subject to satisfactory contractual arrangements.

Blue Shield Informational Meeting — The Board approved a Blue Shield informational meeting for the FMA membership to be held at 8:00 a.m. on Thursday, May 6, in conjunction with the 1982 FMA Annual Meeting.

FMA Auxiliary — The Board reaffirmed the primary role of the Auxiliary as one of support for the activities of the FMA, including emphasis on support for legislative activities and development of active political education programs in cooperation with the FMA Auxiliary in each community, and support of the programs and activities of the Florida Medical Foundation, including fund raising.

The Board endorsed the educational activities of the FMA Auxiliary in regards to infant and adolescent safety programs. The Board expressed the highest commendations and appreciation to the Auxiliary for its dedicated support for the programs and activities of the FMA particularly for assisting in carrying out the FMA legislative program and in FLAMPAC educational activities. The Auxiliary has also made significant contributions to the development of the Association's Impaired Physician Program and in fund raising efforts in behalf of the Florida Medical Foundation. The Auxiliary is vital to the success of virtually every aspect of the Association's activities. The Board wishes to particularly acknowledge the current President of the Auxiliary, Mrs. Frank C. Coleman (Ruth) of Tampa for exemplary leadership during her tenure as President and extends best wishes to Mrs. Daniel Nunn (Gloria) of Jacksonville for a most successful and fulfilling year when she assumes the office of President at the Auxiliary's Annual Meeting in May.

FMA-Sponsored Insurance Programs — Approved changes in the FMA-sponsored insurance programs including:

- **Retired Lives Reserves** — A retired lives program to provide group term life insurance to age 100 using a reserve account built up over the years of the program to continue term insurance after age 70. The reserve account can be funded from tax deductible contributions if the practice is incorporated.
- **Disability Income Program** — Establish a new disability income plan for physicians to improve the existing FMA-endorsed program. All new and present policy holders are eligible for a non-cancellable, guaranteed renewable policy up to \$5,000 per month. Other insureds, if rejected, may receive minimum coverage.
- **AD & D Annuity Program** — A supplement to the existing AD & D program to pay the beneficiary in case of accidental death a lump sum settlement of \$12,000 and \$1,000 per month for life with 20 years certain paid to the estate.

Authorized a modification in the accidental death and dismemberment plan sponsored by the Association to provide for an increase in the level of coverage for participants with no additional increase in premium. Physicians from \$150,000 to \$250,000; spouses \$50,000 to \$100,000; children \$10,000, no change.

FMIT Program — The Board approved modifications for improving the FMIT program to include:

- A conversion program for physicians and employees who leave the insured group.
- An option that the widow or widower may choose within thirty days after the death of the participant to remain on the billing of the group for either single or family coverage at the rate of the widow or widower's attained age. If the widow or widower remarries, they are no longer eligible.

RECOMMENDATION NO. C-4

THAT THE HOUSE OF DELEGATES APPROVE THE FOLLOWING AMENDMENT TO THE FMA BYLAWS TO PROVIDE FOR THE ESTABLISHMENT OF THE FLORIDA MEDICAL ASSOCIATION STUDENT MEDICAL SOCIETY:

**CHAPTER IV, HOUSE OF DELEGATES
SECTION 14, PRIVILEGE OF THE FLOOR**

THE PRIVILEGE OF THE FLOOR SHALL BE RESTRICTED TO SEATED DELEGATES, OFFICERS, PRESIDENTS OF THE COUNTY MEDICAL SOCIETIES, MEMBERS OF THE BOARD OF GOVERNORS, AMA DELEGATES, PAST PRESIDENTS, MEMBERS OF THE COUNCIL ON SPECIALTY MEDICINE, COUNCIL CHAIRMEN, A REPRESENTATIVE OF THE FLORIDA MEDICAL ASSOCIATION STUDENT MEDICAL SOCIETY, AND AMA GENERAL OFFICERS AND PAST PRESIDENTS WHO ARE FMA MEMBERS, EXCEPT BY PERMISSION OF THE PRESIDING OFFICER.

Cancer Care Network of Florida — The Board approved FMA participation in the Cancer Care Network of Florida as a supporting member. The purpose of the non-profit organization is to provide a comprehensive, functional program of cancer care, and control the research in Florida through a cooperative consortium of Florida community hospitals, medical academic institutions, organizations and health care professionals.

Appointments

The Board of Governors approved the nomination of Rufus K. Broadaway, M.D., as the AMA Delegate to serve on the Board of Governors. Frank C. Coleman, M.D., was appointed as optional member of the Executive Committee.

Appointed as advisory members of the Board of Governors were Vernon B. Astler, M.D., Florida Physicians' Insurance Reciprocal and Public Relations Officer; Eugene G. Peek Jr., M.D., Department of HRS; Robert N. Webster, M.D., State Board of Medical Examiners; and Mr. James E. Deming, Medical Student Member.

Norman M. Kenyon, M.D., was appointed as an Assistant Editor of the FMA Journal from the Board of Governors.

Vernon B. Astler, M.D., was appointed as Chairman of the Board of Governor's Committee on Management. T. Byron Thames, M.D., was named Chairman of the Committee on Professional Liability.

Edward R. Annis, M.D., was appointed Chairman of the FMA Speakers Bureau.

Charles K. Donegan, M.D., and Joseph C. Von Thron, M.D., were elected as Chairman and Vice Chairman respectively of Florida's AMA Delegates.

FMA Journal Editor and Editorial Board — The Board enthusiastically approved the President-Elect's nomination of Dr. Daniel B. Nunn, Jacksonville, for reappointment as Editor of the FMA Journal for the Association year beginning in May, 1982.

The Board approved:

For reappointment as Associate Editors:

Clyde M. Collins, M.D., Jacksonville
E. Charlton Prather, M.D., Tallahassee

- Dependent children who are over 19 and not full-time college students, and who are not married and are dependent upon the family for support, whether living at home or not, can be covered up to age 29 by the payment of a single premium per month. Full-time college students will be covered under their parents' policy until they graduate prior to age 23 or, if a full-time college student at age 23, must take a single rate after age 23.
- An increase in the maximum life insurance from \$50,000 to \$100,000. There are two options under the plan:

Option 1: All those presently in the plan will be given the option without medical questionnaire to increase their life coverage at the new rates. Coverage continues at the old rates until June 1, 1981.

Option 2: Physicians joining the plan after September 1, 1981 will be given a new age-rated life program. If they place life insurance on 75% of the employees, there is no health questionnaire. If they do not wish to cover 75% of their employees, life insurance is only available subject to pre-underwriting by use of the health questionnaire.

- Directed that disability coverage for physicians' employees be made available.
- Authorized improved coverage for impaired physicians for medical rather than psychiatric benefits, provided the FMF Committee on Impaired Physicians certifies as to the need.

The Board approved clarifications regarding provisions in the FMIT program relative to retired physicians:

- Retired doctors may not continue their group life insurance beyond the date of their retirement. They have a right to convert to a plan offered by American Heritage Life Insurance Company.
- Retired doctors may continue their health insurance until age 65. If less than 65 and/or eligible for Medicare, they may cancel their health insurance; and we can write a Medicare wrap-around policy.
- Persons who are currently disabled or not working at the time they apply for insurance coverage are ineligible to join the program until they resume full time work; full time being 20 hours per week for health insurance, and 30 hours per week for life insurance.
- Physicians who have attained the age of 65 are not eligible for the \$50,000 extra or optional life insurance over the basic \$50,000. Physicians who are currently over age 65 and carrying \$100,000 worth of life insurance must be reduced to the basic \$50,000.
- Effective June 1, 1982, the basic \$50,000 life insurance will be reduced to 65% of the face amount between the ages of 65 and 70 if the physician is still working. All life insurance coverage is to terminate at the age of 70.

FMA Student Medical Society — The Board considered a proposal submitted by Mr. Jim Deming, the medical student representative on the Board of Governors, for establishment of the Florida Medical Association Student Medical Society. The general nature and objects of the Society shall be to promote the science and art of medicine and the betterment of public health; to encourage and support the active participation of medical students in the activities and goals of organized medicine through the Florida Medical Association; and to support the purposes of the FMA. (Included as Enclosure #2 to the *Delegates Handbook*)

The Board enthusiastically endorsed the proposal and commended Mr. Deming for his foresight in putting forth this most appropriate and worthy idea.

For reappointment as Assistant Editors:

Francis C. Coleman, M.D., Tampa
James K. Conn, M.D., Tallahassee
Lee A. Fischer, M.D., West Palm Beach
Henry L. Harrell Jr., M.D., Ocala
Edward Pedrero, M.D., Tampa

For reappointment as Book Review Editor:

F. Norman Vickers, M.D., Pensacola

For reappointment as Historical Editor:

William M. Straight, M.D., Miami

FMA Awards

A. H. Robins Award — The Board reviewed nominations received from county medical societies and selected the recipients of the A. H. Robins Award "For Outstanding Community Service by a Physician". This award will be presented at the First Meeting of the House of Delegates on May 5, 1982. The recipient for this year's award will be included in the Delegates' Packets.

Distinguished Layman Award — The Board has selected the 1982 recipient of the Distinguished Layman Award. The appropriate citation, along with the criteria, will be included in the Delegates' Packets.

Excellence in Medical Journalism — The Board approved continuation of the Association's Excellence in Medical Journalism Award for 1982 to recognize outstanding accomplishments by the news media related to medical topics.

Medical Speakers Award — The Board approved the establishment of an FMA-sponsored Speakers Award to acknowledge exemplary medical speakers who have distinguished themselves via the electronic media and before live audiences.

Medical Malpractice Prevention Award — The Board approved establishment of a Medical Malpractice Prevention Award to be sponsored by the Florida Physicians' Insurance Reciprocal to recognize physicians and other individuals who have distinguished themselves through activities relating to medical malpractice prevention.

Medical Seminars — The Board approved four medical seminars to be sponsored by FMA and the Auxiliary through INTRAV during 1982. A Scandinavian Adventure (sponsored by the Auxiliary) for 15 days will leave from Miami, Tampa and Jacksonville July 5, returning on July 19, 1982. It will feature deluxe visits to Stockholm, Helsinki, Oslo and Copenhagen and a cruise on the Swedish Archipelago. The Alpine Adventure (sponsored by FMA) will be a deluxe two-week trip to Switzerland and the Italian Lake Region. It will have departures from Jacksonville, Tampa and Miami on July 18 and will return July 31, 1982. The European Capitals Adventure (sponsored by the Auxiliary) leaves from Miami, Tampa and Jacksonville on September 8, and returns September 21, 1982. It will include two weeks in the world's most popular cities, Paris, Rome and London. An exciting 15-day Orient holiday package (sponsored by FMA) will leave from the same Florida cities on September 30, and return October 14, 1982. The Far East Adventure will feature stops in Tokyo, Kyoto, Singapore and Hong Kong.

Nominations:

Certificate of Merit — The Board selected an outstanding physician for nomination to the House of Delegates to receive the Certificate of Merit for 1982 (the Association's highest honor of achievement). This nomination will be included in the Delegates' Packets for approval by the House of Delegates.

Certificate of Appreciation — The Board selected two physicians to be nominated to the House of Delegates as recipients of the 1982 Certificate of Appreciation. These nominations will be included in the Delegates' Packets for approval by the House of Delegates.

Judicial Council — In compliance with the FMA bylaws, the Board of Governors has considered nominations for terms expiring on the Judicial Council in 1982. The Board wishes to nominate Joseph H. Davis, M.D., for re-election to the Judicial Council as the representative for Medical District D for a five-year term on the Judicial Council.

Committee on Membership and Discipline — The Board will submit nominations to the House for election to the Committee on Membership and Discipline in a supplemental report.

AMA Awards

The Board expressed its sincerest commendation to Dr. Jean Jones Perdue of Miami upon her selection as the recipient of the AMA Benjamin Rush Award. The Board further voted its full support for the nomination of Dr. Joe Davis of Miami as the recipient of the AMA Distinguished Service Award.

Supplement to Report C of the Board of Governors

The Supplement to Board of Governors Report C, Nominations for Committee on Membership and Discipline, was adopted.

Supplement to Board of Governors Report C

The following supplement report of the Board of Governors has been prepared summarizing actions which were not included in the Board's report in the *Delegates Handbook*.

Committee on Membership and Discipline

In compliance with the Bylaws, the Board has reviewed terms expiring in 1982 on the Committee on Membership and Discipline. Nominations from county medical societies have been considered, and the Board nominates the following physicians for election to the Committee on Membership and Discipline for the terms indicated.

District 1	Lealis L. Hale Jr, M.D. (86)
District 2	James M. Dell Jr, M.D. (86)
District 3	Samuel J. Alford Jr, M.D. (86)
District 4	H. Frank Farmer Jr, M.D. (86)

District 5	Ross G. Olson, M.D. (86)
District 6	James T. Fleming, M.D. (86)
District 7	J. Robert Qualey, M.D. (86)
District 8	Thomas R. Busard, M.D. (86)
District 9	Francis S. Pooser, M.D. (86)
District 10	Fred S. Carter, M.D. (86)
District 11	Luis R. Guerrero, M.D. (86)
District 12	Peter A. Tomasello, M.D. (86)
District 13	Sheldon Zane, M.D. (86)
District 14	Chester Cassel, M.D. (86)
District 15	Norman L. Gottlieb, M.D. (86)

Supplement to Report C of the Board of Governors

The Supplement to Board of Governors Report C, Bylaws Change, was adopted.

Supplement to Board of Governors Report C

The following supplemental report of the Board of Governors has been prepared summarizing actions which were not included in the Board's report in the *Delegates Handbook*.

RECOMMENDATION NO. C-5

THAT THE HOUSE OF DELEGATES APPROVE THE FOLLOWING AMENDMENT TO THE FMA BYLAWS TO PROVIDE FOR A CHANGE IN THE NAME OF THE COUNCIL ON HEALTH CARE FINANCING TO THE COUNCIL ON MEDICAL ECONOMICS.

CHAPTER VIII — COUNCILS

3. Medical Economics

Section 3., Item 3., **THE COUNCIL ON MEDICAL ECONOMICS** shall monitor such programs as health, planning, Worker's Compensation, Medicare, Medicaid, and other government health care programs, and shall maintain liaison with the government agencies administering them.

Report F Board of Governors

Report F of the Board of Governors was adopted.

Report F Board of Governors Sanford A. Mullen, M.D., Chairman

The Board of Governors reviewed in detail the certified public audits prepared by Harbeson, Beckerleg and Fletcher for the Florida Medical Association, Inc., the Florida Medical Foundation, Inc., the Florida Physicians' Insurance Reciprocal, the Professional Insurance Management Company,

FLAMEDCO, Inc., FLAMPAC, and the Florida Physicians Association, Inc. The Board of Governors found no exceptions in these audits and approved these reports as presented.

Report of Public Relations Officer

The Report of the Public Relations Officer was adopted.

Public Relations

Vernon B. Astler, M.D., Public Relations Officer

The success of the FMA's public relations program is measured by how society views the physician. The key to the program is you the individual members, your relationship with your patients in the community, and the support you receive from the Officers, Board of Governors and our staff in portraying a positive image for organized medicine.

Since its inception, the Association's public relations program has continued to gain credibility and plaudits from various professional elements and the media for its efforts to educate the public. The latest of these include the Association's film "Edge of Life" which won first place during the 1981 Kinetic Film Festival and was one of two films in the state nominated for an Emmy as an independent production by the Florida Chapter of the National Academy of Television Arts and Sciences. Publicity generated by our staff and AMA about its honors led to a total revival of requests nationwide for all three of the Association's films. This resulted in a backlog of requests that took several months to fill.

There are numerous other positive factors contained in this report but it should be recognized there are serious challenges facing organized medicine and we are preparing a public relations program to deal with a number of these areas. The foremost problem facing the physicians of Florida is malpractice and strong efforts are going to be made to educate the public as to this continuing crisis. There are already ongoing efforts by the Association to cope with and hopefully roll back the tide of government intervention in the private practice of medicine. One of the largest problems that we are going to face during the 80s is the aged. Research has shown that of all the people in the world that have been born and obtained the age of 65, half of them are still alive today. They are a powerful force and constitute a separate public to whom we must address ourselves.

The Association is also studying ways to reach the interns and residents who will be the physicians and leaders of organized medicine tomorrow. Again, research has shown the county societies, the FMA and even the AMA are too often viewed as an "Old Boys Club". FMA must and will develop and implement programs to make it easier for these young people to join the ranks of organized medicine and to demonstrate that we all have more common interests than differences. Everyone can best serve and be served in the ranks of organized medicine.

One of the true elements of any good public relations program is responsiveness and FMA was able to demonstrate this ability again during the past year when called upon by the Florida Ophthalmology Society to assist in over-night development of a media kit and legislative education materials concerning the Optometric Drug Issue. Our staff also handles numerous media calls which seek immediate answers and information from reporters working with deadlines only hours away.

Another ongoing portion of the Association's public relations program is assistance to FLAMPAC in developing and preparing educational materials. The Communications Department produces four newsletters a year for FLAMPAC. During the past year,

we prepared a new brochure for the PAC, a series of advertisements for county society publications and a membership promotion card that we supplied with all dues statements. In addition, our staff worked in conjunction with the Association's national public relations consultant in developing the concept and plans for the new Medical Action Team.

The highly successful Excellence in Medical Journalism Contest continues to be a part of the public relations program and two new contests were launched this year. They are the Medical Speakers Award Program for county societies and the Malpractice Prevention Award Program.

Surveys continue to show us that our *Medical Message* column is well received as does the number of clippings received in the Headquarters Office from publications carrying the column. Also of great importance as to our efforts are the numerous requests from schools and parent groups for reproduction and distribution rights of our *High School Medical Message* column.

During this past year, the Communications Department conducted a state-wide media visitation program in conjunction with county medical society officers and executives. This program led directly to several new radio programs now being carried out by county societies, a new commercial television series and the development of "flip card" public service announcements for radio stations throughout the state.

One other specific example as to the value of the visitation program is that a chain of 14 weekly newspapers immediately began and continue to carry our *Medical Message* column.

The Communications Department also has the responsibility for the golf tournament during the Annual Meeting. Last year, 52 participants took part and during this Annual Meeting the field is expected to reach a capacity of 82 players.

Our Communications Department also participates actively in the affairs of the Florida Press Association and the Florida Association of Broadcasters. During 1982, FMA's Director of Communications received the Florida Association of Broadcasters Service Award recognizing FMA's involvement and support of the broadcasters efforts.

The entire FMA staff has expanded the Association's efforts in communications and participation with county society officers and executives in all phases of the activities necessary to keep our member-physicians and the public aware of the positive aspects of organized medicine. However, without the continued, dedicated efforts of each FMA member, such efforts are not enough. You, the physician, will always be the primary public relations person for organized medicine.

Committee on AMA Delegates

The Report of the Committee on AMA Delegates was adopted.

Committee on AMA Delegates

Charles K. Donegan, M.D., Chairman

It has been my pleasure to serve as Chairman of your Florida AMA Delegates during the past year and I greatly appreciate the able assistance provided by the Vice Chairman, Joseph C. Von Thron, M.D., Cocoa Beach.

I was honored to accept election as Chairman of the Delegation to replace Dr. James T. Cook Jr., who resigned as an AMA delegate and Chairman of the Delegation after many years of service. Your entire delegation is deeply indebted to Dr. Cook for his many contributions on behalf of the physicians of Florida, and for his counsel in guiding the activities of our delegation.

I wish to thank all of our delegates and alternate delegates who have given freely of their time and efforts in support of the best

interest of all Florida physicians in addressing the many issues to come before the AMA House of Delegates:

Samuel M. Day, M.D., Jacksonville (Delegate)
Burns A. Dobbins Jr., M.D., Fort Lauderdale (Delegate)
Richard G. Connar, M.D., Tampa (Delegate)
Rufus K. Broadaway, M.D., Miami (Delegate)
Joseph C. Von Thron, M.D., Cocoa Beach (Delegate)
T. Byron Thames, M.D., Orlando (Alternate)
Vincent P. Corso, M.D., Miami (Alternate)
Luis M. Perez, M.D., Sanford (Alternate)
Francis C. Coleman, M.D., Tampa (Alternate)
Eugene G. Peek Jr., M.D., Ocala (Alternate)
Vernon B. Astler, M.D., Boynton Beach (Alternate)
William J. Dean, M.D., St. Petersburg (Alternate)

A special note of commendation is extended to the alternate delegates for their continued interest and attendance at all meetings, including reference committees and sessions of the House of Delegates. We are pleased to welcome two new members to our delegation whose terms began January 1, 1982: Dr. Charles J. Kahn was elected to serve as alternate for Seat #6; and Dr. James W. Walker was elected to serve as alternate for Seat #7. In addition, Dr. Byron Thames was elected to fill Delegate Seat #1. Dr. Robert J. Brennan, representing Allergy, and Dr. Thomas D. Bartley, representing Thoracic Surgery, have participated in all our activities at each meeting of the House and have made significant contributions in support of Florida's overall efforts.

It should be noted that the FMA officers and representatives of the Board of Governors, as well as numerous officers, executive staff and others from FMA's component county medical societies have attended the meetings and willingly supported the activities of our delegation.

The incessant attacks on our private system of health care delivery continue unabated and have once again been reflected during the past year in the large volume of issues to come before the House. The following is a summary of the major actions taken by the House, and of the activities of your Florida delegates during the past year, including the Annual Meeting, June 7-11 and the Interim Meeting, December 6-9. Your delegates have submitted written reports on activities to the FMA Board of Governors and to the FMA membership through Association publications.

Candidates for Elective Office

With the approval of the Board of Governors, the Florida Delegation was pleased to support Florida physicians who were candidates for AMA elective office at the 1981 Annual Meeting. Dr. Henry McIntosh of Lakeland, and Dr. Linda Marraccini, a Resident at Jackson Memorial Hospital, were nominated by the Board of Trustees for election to the Council on Scientific Affairs and the Residents Physician position on the Council of Medical Education respectively. Both candidates were well received, but were unsuccessful in their first effort to gain elective office.

Dr. William Deal was nominated by the AMA Board of Trustees to fill an unexpired term on the Council of Medical Education. Your delegation was pleased to endorse his candidacy and assist him during the meeting in conducting his campaign. While Dr. Deal was not successful, he is to be commended for his enthusiastic efforts particularly on such short notice. There was absolutely no time in advance of the meeting in which to prepare any formalized campaign.

Your entire delegation enthusiastically supported the candidacy of Dr. Rufus K. Broadaway for election as AMA Vice Speaker at the AMA Annual Meeting. We regret that Dr. Broadaway was unsuccessful and that Dr. James E. Davis of North Carolina was elected to this post. It should be noted that Dr. Broadaway received wide support in the election that he lost by a narrow margin of votes.

AMA Board of Trustees

With the approval of the Board of Governors, your delegation is working diligently on behalf of Dr. Broadaway's candidacy for election to the AMA Board of Trustees at the 1982 Annual Meeting. Of the four positions that are open on the Board, there will be two incumbents seeking reelection and two open positions. While there is an outstanding field of candidates for this office, your delegation feels that Dr. Broadaway has an excellent chance of being one of the four candidates that will be elected.

Florida Eighth Delegate

Your delegation is pleased that due to an increase of AMA membership in Florida during 1981, that we will have an increase in the number of delegates to the AMA House of Delegates beginning with the 1982 Annual Meeting. As of December 31, Florida had 7,451 active members in the AMA which entitled us to one additional delegate, bringing our total number to eight. The delegate and alternate delegate elected by the FMA House of Delegates in May for this additional seat will serve at the AMA Annual Meeting in June.

Southeastern Delegation

Your delegation continues to participate in the Southeastern Delegation which is currently comprised of the following states:

Alabama	Maryland
Delaware	Mississippi
District of Columbia	North Carolina
Florida	South Carolina
Georgia	Virginia
Louisiana	

Puerto Rico has been invited to become a member of the delegation.

Activities at the Annual and Interim Meetings have included a breakfast caucus on Sunday morning, at which time the major items of business to be addressed by the House were discussed, and a reception sponsored by the delegation on Monday evening.

Resolutions

The Florida Delegation introduced one resolution at the Annual Meeting in June entitled "Medical School Malpractice Risk Prevention Curriculum." The substitute resolution adopted by the House called for the AMA to:

- Acknowledge the continuing and growing severity of the problem of physician professional liability insurance nationwide; and
- Urge medical schools and directors of residency programs to assist students and residents to understand and apply the determinants of quality medical care that will reduce the incidence of unwarranted suits for alleged negligence.

The Florida Delegation had planned to introduce one resolution at the Interim Meeting regarding the AMA criteria for soliciting direct membership which had been submitted to the Florida Delegation by the Pinellas County Medical Society. However, AMA legal counsel expressed concern that the resolution raised some legal problems and it was requested that the resolution be withdrawn. Your Chairman discussed this matter with the AMA legal counsel, and after receiving assurance that the intent of the resolution would be carried out on a voluntary basis by the AMA in soliciting direct membership, it was agreed that the resolution be withdrawn. If the intent of the resolution is not carried out as agreed, the delegation will reconsider introducing it at the Annual Meeting in June. The resolution provided that the AMA, in implementing the direct membership program, allow constituent state medical societies to screen prospective direct members prior to their being solicited for AMA direct membership.

House Actions of Major Importance

The following is a summary of major actions taken by the House of Delegates:

1. **Abolishing Health Systems Agencies:** Resolved, that until Health System Agencies are abolished, the American Medical Association seek a legislative amendment in Congress or an administrative exemption removing those portions of the Health Planning Act which impose penalties on states not in compliance with Federal State Health Planning and Development Agency designation criteria.
2. **Repeal of PSRO Legislation:** The House voted to reaffirm current policy to continue physician directed efforts to ensure that care provided patients is of high quality, appropriate duration and is rendered in an appropriate setting at a reasonable cost and to encourage the elimination of all government directed peer review programs including PSRO.
3. **Repeal of "Con" Statute:** Adopted a resolution that AMA continue to seek repeal of federal legislation which mandates certificate of need statutes; and calls for state associations who oppose certificate of need, seek repeal of such statutes in their state legislature following repeal of the federal requirement.
4. **Discontinuance of Funding for HMO's and Subsidization of HMO's:** The House voted that the American Medical Association continue to support the elimination of governmental funds for new start-ups of HMO's and the termination of governmental funds for other HMO's after completion of the current funding cycle.
5. **AMA Dues Increase:** The House approved raising AMA regular dues for physicians in 1982 to \$285 and the House will consider an increase of the regular dues to \$315 in 1983 and to \$340 in 1984, subject to the wishes of the House in 1982 and 1983.
6. **Direct Membership in AMA** was adopted by the House of Delegates. The final resolution called for the Board of Trustees to report to the House after one full year of experience with the direct AMA membership option, providing a full review and reappraisal of the program. Subsequently, the House adopted a Bylaws change to implement direct membership with definitions as to eligible applicants.
7. **Support of President Reagan's Program for Reducing Federal Spending and Government Regulations:** Resolved, that AMA continue to support the objectives of the President as he seeks to revitalize the nation's economy and restore fiscal integrity to federal budget policy by reducing federal spending, reducing federal regulations, and reducing federal taxes.
8. **Repeal of the Economic Index applied to Medicare Reimbursement:** Accepted a draft of legislation which would eliminate from Medicare the economic index, would update charge levels more frequently and would allow new physicians to be reimbursed at the 75th percentile. Progress is to be reported to each session of the House.
9. **Patient Signatures for Medicare Payment:** The House endorsed proposal to permit all physicians to use the patient signature on hospital records in completing any claim form accepted by HCFA for Medicare payment for inpatient hospital care.
10. **Elimination of Federal Funding for Training of Midlevel Practitioners:** This resolution was adopted with specific language that legislation to increase public funding for programs to train physician's assistants and nurse practitioners be opposed, and that there be careful reevaluation of the need for public funding at the time that present legislation expires. The Board of Trustees was also instructed to study the definition of midlevel practitioners.
11. **Statement on Foreign Medical School Graduates:** Adopted the position, "The AMA supports the practice of U.S.

teaching hospitals and foreign medical educational institutions entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. Medical educational programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experience provided by U.S. institutions for the core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine."

12. **Health Care of the Aged:** Passed a resolution urging all appropriate specialties to emphasize further education and research on the problems of the aging and health care of the aged at medical school, graduate and continuing medical education levels. At the same time, the House took a stand that in support of the concept that development of a formal practice specialty in geriatrics would be divisive and dilute the present efforts by a number of concerned specialties currently addressing the problems of the elderly.
13. **Commercial Review of Hospital Utilization:** Resolved, that the American Medical Association notify all agencies involved in medical peer review that the medical peer review be done only by physician-sponsored organizations.
14. **Increase in Medical Liability Claims:** The Board of Trustees was instructed to continue to investigate the current medical liability situation as they have for the past several years, and to report back in 1982, and annually thereafter, its findings and any remedial action taken or contemplated.
15. **Health Care Cost Containment:** The House considered a number of reports relating to health care cost containment. The House endorsed participation in health care coalitions emphasizing the vital importance of meaningful physician participation in policy-making roles in addressing the vital issue of health care cost containment, and further noted the desirability of decentralizing cost containment efforts with major emphasis at the local level.

The House adopted two Board reports summarizing recent developments on pro-competition proposals and called for renewed emphasis by the AMA on monitoring the proposals currently before the Congress. The House expressed concern that the increase in health cost may intensify attempts to restructure, in an adverse manner, the current medical market place posing severe jeopardy to the existing system of free enterprise medicine.

16. **Physician Participation in Medicaid:** The House reviewed a proposal for a major revision in the Medicaid program which would have provided for tax credits or deductions to physicians for care of indigent patients in lieu of reimbursement. The House concluded that the concept was not appropriate at this time because of the difficulty in assessing legitimate charges as opposed to Medicaid payments; the introduction of the IRS into the reasonable charge determination; the probable public response to perceived increased financial rewards to physicians for treating the poor; and the anticipated unfriendly reception in Washington.
17. **Affirmative Leadership by Physicians:** The House applauded the address of AMA President, Daniel T. Cloud, M.D., and his call for physicians to exert affirmative leadership roles in addressing the increasing problem of health care cost and all of its contributing factors.
18. **Voluntary Peer Review Programs:** The House adopted principles for voluntary peer review including:

- Medical peer review is an organized effort to evaluate and analyze medical care services delivered to patients and to assure the quality and appropriateness of these services.

Peer review exists to maintain and improve the quality of medical care.

- Peer review is a local process.
- Physicians are ultimately responsible for all peer review of medical care.
- Physicians involved in peer review should be representatives of the medical community and participation must be structured to maximize involvement of the medical community. Any peer review process must provide for consideration of the views of individual physicians, groups of physicians, or institutions under review.
- Peer review evaluations are based on appropriateness, medical necessity, and efficiency of services to assure quality medical care.
- Any system of medical peer review must have established procedures.
- Peer review of medical practice and the patterns of medical practice of individual physicians, groups of physicians, and physicians within institutions is an ongoing process of assessment and evaluation.
- Peer review is an educational process for physicians to assure quality medical services.
- Any peer review process must protect the confidentiality of medical information obtained and used in conducting peer review.

19. **Continuing Medical Education Rules:** The House adopted tighter standards for creating continuing medical education programs contingent upon subsequent approval of the Accrediting Council for Continuing Medical Education Handbook which is intended for use in evaluating national organizations, medical societies, academic centers, and hospitals that offer CME.

20. Other Actions:

- Advocated that the supply of physicians be determined by freemarket forces rather than by a regulatory process and pledged to provide physicians with information that would help them choose specialty and geographic areas that require their services.
- Warned of the "potential misuse" of the tentative findings of Graduate Medical Education National Advisory Committee (GMENAC).
- Urged state licensing authorities to continue to recognize the National Board of Medical Examiners' certificate for the purposes of medical licensure, and support a single Federation Licensing Examination (FLEX) instead of the proposed FLEX I — FLEX II concept.
- Called for continued publicizing of AMA's willingness to make negotiations expertise available for AMA members or county and state associations that need such resources.
- Filed a progress report by the Council on Long Range Planning and Development on the Council's study of participation by young physicians in organized medicine.
- Endorsed model legislation to ban the manufacture, sale, and distribution of imitation controlled substances, commonly known as "look-alike" drugs.
- Approved a Board report on federal budget reductions approved by Congress this year, noting that the bloc grant provisions of those reductions address many of the concerns of resolutions referred to the Board during last June's annual session.
- Approved designation by the Health and Human Services Secretary of a central maternal and child health office.
- Called for continued monitoring of the development of regulations that cover the reimbursement for physicians in teaching hospitals with large Medicaid teaching loads.

- Approved a Board report describing AMA activity in representing Association policy to Congress regarding the National Health Service Corps and voluntary payback program.
- Opposed federal intervention into physicians' prescribing practices.
- Urged physicians to become more involved in pre-crisis intervention in the treatment and in the integration of chronic mentally ill patients into the community in order to prevent unnecessary hospitalization or jail confinement.
- Agreed to make known to physicians, the lay public, and third party payers that physicians in the private sector are at the forefront of mental health care in their office practices, and provide significant amounts of direct and preventive mental health services to the public.
- Rejected a move to enact legislation restricting hospital admission privileges to physicians.
- Adopted a report defining clinical privileges for physicians with newly acquired skills.
- Adopted a policy emphasizing the right of hospitalized patients to choose their own physicians.
- Allowed medical students to serve as delegates from state medical societies.
- Adopted Judicial Council Report A on the pros and cons of charging interest on delinquent accounts.

FMA Speakers Bureau

The Report of the FMA Speakers Bureau was adopted.

FMA Speakers Bureau

Edward R. Annis, M.D., Chairman

Media and political demands for hospital cost containment and a lowering of physician's fees for professional services played a large role in subject matter addressed by the Speakers Bureau this past year.

So-called pro-competition bills which have been introduced in Congress have caused the Speakers Bureau, comprised of the officers and Board of Governors, to emphasize that such proposals concentrate only on cost with almost a total disregard for the distribution and quality of services rendered. In addition to espousing accurate information on many of these problems directed to the profession at county medical society meetings around the state, there has been an expanded effort to educate and inform the public. It is extremely important to get the message out that arbitrarily mandated cost limitations can only come about by delaying care, denying care, or giving less than the best of care.

In our presentations, county societies have been encouraged to increase their efforts to inform consumers via letters to the editor, addresses before civic clubs, women's clubs, chambers of commerce and others. Even more important, physicians in all communities should take the opportunity when available to tell organized medicine's story over radio and television.

Even though physicians get only 19% of the health care dollar, they still constitute the major target for critics of escalating costs. Hospitals consume approximately 40% out of every dollar, and almost overlooked is the other 40% in nursing homes, extended care facilities, transportation facilities, and a number of others repeatedly demonstrated to be the greatest focal point for waste, fraud, abuse and sheer thievery.

Your Speakers Bureau encourages all physicians to participate in the necessary efforts to educate our patients because, in the long run, they are our best allies and still support us in demanding a proper role for quality and availability of medical services.

Florida Medical Foundation

The portions of the Report of the Florida Medical Foundation considered by Reference Committee III were adopted.

Florida Medical Foundation

Eugene G. Peek Jr., M.D., President

The Florida Medical Foundation continued to play a major role in Florida Medicine through its many and varied activities. Members of the Board of Directors of the Foundation have held their meetings in conjunction with meetings of the Florida Medical Association Board of Governors. The major activities of the Foundation during 1981 are summarized below:

Peer Medical Utilization Review (PMUR)

A detailed report on the activities of the Peer Medical Utilization Review Committee of the Foundation is summarized in the Annual Report of the Council on Health Care Financing which is included in the *Delegates Handbook*. As indicated in the report, the future of PMUR activities conducted by the Foundation through contract with Blue Cross and Blue Shield for Medicare is in doubt. This is due to recent cuts in the Medicare administrative budget and a determination of funds to be made available to the carrier for purposes of contracting for PMUR services. The Foundation, at the direction of the FMA Board of Governors, is making every effort to negotiate with Blue Shield for continuing this program based on drastically reduced funds with continued participation by FMA component county medical societies in the PMUR process. (R.C. V.)

Committee on Continuing Medical Education

The Committee, headed since its inception by Robert H. Threlkel, M.D., of Jacksonville, added the "Continuing" to its name last June to pinpoint its area of interest in medical education.

As an organization accredited by the Accreditation Council for Continuing Medical Education and the Florida Medical Association for continuing medical education, the Committee continues to make significant contributions to CME in Florida. During 1981, the Committee received 33 applications for its co-sponsorship and certification of AMA Category I Credit from various hospitals, specialty groups and other providers of CME. These applications resulted in more than 530 hours of American Medical Association Category I Credit being made available to Florida physicians.

At the time of preparation of this report, five applications seeking certification of 47 hours of CME had been received since the end of 1981. (R.C. I.)

Committee on Impaired Physicians

The Foundation is pleased that the FMA has continued to provide funds for further implementation of the Impaired Physician Program which was formally begun at the direction of the FMA House of Delegates in 1980. A comprehensive report on this important program is included in the *Delegates Handbook*. Discussions are currently underway between FMA representatives, including Dr. Gerold L. Schiebler, FMA Vice President; Dr. J. Russell Forlaw, Treasurer; and Dr. Guy T. Selander, Chairman of the Impaired Physicians Committee, with representatives of the State Board of Medical Examiners and the Secretary of the Department of Professional Regulation regarding the possibility of funding assistance for the program from the Board of Medical Examiners. We are

optimistic that a legislative appropriation will be approved by the current session of the legislature which will provide the moneys necessary to insure an adequate level of funding for full implementation of the program. The Foundation wishes to commend the dedicated efforts of the Committee in helping to make this important program a reality: Guy T. Selander, M.D., Jacksonville, Chairman; Dolores A. Morgan, M.D., Miami, Medical Director; Theodore I. Marshall, M.D., Pensacola; George S. Palmer, M.D., Tallahassee, Department of Professional Regulation; John M. Butcher, M.D., Sarasota; Arvey I. Rogers, M.D., Miami; and Mrs. F. J. Weigand, Deltona, Florida Medical Association Auxiliary Representative.

Emergency Medical Services Project

In December 1981, the Foundation entered into an Emergency Medical Services contract with the Department of Health and Rehabilitative Services. The services the Foundation will provide under this agreement include:

- A state-wide analysis of emergency medical and critical care services, both pre-hospital and hospital.
- The development of a five-year plan for Florida's emergency medical service system.
- Medical direction of the state EMS office.

The EMS Project is now fully operational with an office in Jacksonville. The medical director is Raymond H. Alexander, M.D., a surgeon, and the assistant medical director is Peter T. Pons, M.D., an emergency physician. The Florida Medical Association's Committee on Emergency Medical Services, chaired by Roy M. Baker, M.D., is the official steering committee for the project. (R.C. II.)

Medical Student Loans

The Foundation continues to have a Student Loan Program administered through the Florida First National Bank of Jacksonville with the Foundation serving as the guarantor. A moratorium still exists on the program until sufficient loans have been repaid to remove the threat to the solvency of the Program. Since the last Annual Report, the number of in-school loans has been reduced from eleven (11) loans with a loan balance of \$30,334.80 to nine (9) with a loan balance of \$23,965.22. There are forty-seven (47) loans in the repayment status which total \$63,225.84. The Foundation as guarantor has had to make no payoffs during 1981. The Foundation is actively pursuing the collection of all defaulted loans. (R.C. I.)

Nutrition Textbook

The Special Nutrition Issue of *The Journal of the Florida Medical Association, Inc.*, published in 1979, received national acclaim and as a result, has been published in textbook form. Four new chapters were added along with the Foreword and References updated. The textbook, which is published by AVI Publishing Co., Inc., of Westport, Connecticut, is available for sale with royalties being shared equally among the Foundation and Florida's three medical schools, who participated in the joint venture. (R.C. I.)

Florida Medical Association Auxiliary

A very special note of appreciation is expressed to the Florida Medical Association Auxiliary which, through its many fund raising projects, has donated in excess of \$4,000 to the Foundation in 1981.

Committee on Impaired Physicians

The Report of the Florida Medical Foundation's Committee on Impaired Physicians was adopted.

Committee on Impaired Physicians

Guy T. Selander, M.D., Chairman

The Florida Medical Association and Florida Medical Foundation Impaired Physician Program now has more than a year of experience in identifying and channeling into treatment programs physicians considered to be impaired by reason of alcoholism and/or drug addiction.

Up to February 29, 1982, the cases of 62 licensed professionals — 55 M.D.'s, four dentists, one veterinarian and two D.O.'s — had been referred to and evaluated by the Medical Director. Of the 62 cases, 22 were alcohol-related, 25 were drug-related, 13 were a combination of alcohol and drugs, and two were neither. The disposition of the 62 cases were as follows:

Evaluation Only	22
Outpatient Group Only	6
One Month Treatment	9
Four Months or More Treatment	25
	62

Three patients did not complete the one-month treatment program, and two cases are now deceased — one from a cocaine overdose and one from a heart attack. The State of Florida has suspended four licenses because of impairment — three physicians and one dentist.

Quite obviously, it will be some time yet before the long-term effectiveness of the program can be assessed, but the results so far are quite encouraging.

Beyond the statistics cited above, the activities of the Florida Medical Foundation Committee on Impaired Physicians are summarized below:

1. **Meetings:** In the past year the Committee has met twice. The first meeting was in Tampa on September 25, 1981 in conjunction with the Second Intervention Workshop sponsored by the Committee (see below). The second meeting was in St. Petersburg Beach on December 4, 1981, and was followed on December 5 by a joint meeting with the Florida State Board of Medical Examiners. The Chairman is most grateful for the continued, almost perfect, attendance at the Committee meetings.
2. **Meeting with Board of Medical Examiners:** As mentioned above, the Committee held a brief meeting with the Florida State Board of Medical Examiners on Saturday, December 5. The purpose of the joint meeting was twofold: (1) to brief the Board on the progress, procedures and philosophy of the Impaired Physician Program; and (2) to enlist the Board's support for state assistance in funding the program. The latter matter had not been resolved by the Legislature at the time this report was prepared.
3. **Medical Director:** Since our program began, Dolores A. Morgan, M.D., of Miami, had served as the parttime Medical Director. Dr. Morgan has performed an outstanding and valuable service in this role, but she has advised the Committee that because of her other professional responsibilities she will be unable to continue in the position beyond June 30, 1982. The program has reached the point where the employment of a fulltime medical director is highly advisable. Whether this is possible will depend on what the Legislature decides with regard to state participation in the funding.
4. **Intervention Workshops:** The Committee has conducted two two-day Intervention Workshops — in Miami and Tampa — and these have been attended by a total of 55 physicians. The purpose of these workshops is to train physicians in the technique of confronting their impaired colleagues and guiding them into appropriate treatment programs.

5. **Speaking Engagements:** Representatives of the Committee have accepted a number of speaking engagements. The Chairman addressed the Annual Meeting of the Florida Hospital Association in 1981. County medical society appearances have included Collier, Palm Beach, Duval, Polk, Sarasota, Charlotte, Broward, Hillsborough, Volusia, Manatee, Lee, and DeSoto-Hardee-Glades. In addition, several hospital medical staffs and county medical society auxiliary units have been covered.
6. **Voluntary Contributions/Loan Fund:** The Committee has raised a substantial sum of money in the form of voluntary contributions over and above the budgeted operating funds. Most of this money has been raised through the sale of the Lee Adams "Caduceus" prints. An unframed print is given in return for contributions of \$300 or more to the Impaired Physician Program.
It is the desire of the Committee to use these voluntary contributions as a source of low interest loans to assist needy impaired physicians in paying for their treatment. Appropriate recommendations to activate this loan program have been made to the FMA Board of Governors.
7. **FMA Section on Chemical Dependency:** For the second straight year, the Committee will sponsor a scientific section on Chemical Dependency at the FMA Annual Meeting. This year's session is scheduled for 8:00 a.m. to 10:45 a.m. on Friday, May 7, at the Diplomat Hotel in Hollywood. The featured speaker will be John-Henry Pfifferling, Ph.D., Medical Anthropologist and Founder, Center for the Well-Being of Health Professionals, Chapel Hill, N.C. All FMA members are invited to attend the Section and hear Dr. Pfifferling.
8. **Insurance Coverage:** The Committee believes very strongly that the FMA-sponsored insurance plans should provide treatment and disability benefits for members undergoing treatment for alcoholism or drug addiction. Recommendations to bring about this inclusion have been forwarded to the FMA Board of Governors.
9. **Treatment Facilities:** Most of the physicians being referred to our Impaired Physician Program are being treated either at South Miami Hospital or at Ridgeview, near Atlanta. The Committee hopes to be able to approve other Florida facilities for participation in the treatment program. Caduceus Clubs, important in the post-treatment monitoring, have been formed in Miami, Tampa, Palm Beach and Ormond Beach.
10. **County Medical Society Committees:** The Committee continues to encourage the formation of impaired physician committees at the county medical society level. This is particularly important in the larger societies. The Committee is pleased to note that many societies have formed such committees and they seem to be operating quite effectively.
11. **Impaired Physician Hot Line:** The Impaired Physician Hot Line continues to be available for the use of physicians and spouses in reporting impaired physicians to the program. The number is: (305) 667-8717.

The Committee is grateful to *The Journal* for agreeing to publish an advertisement each month promoting the use of this number.

12. **Psychiatry:** One of the most unfortunate problems the Committee has been forced to endure are the allegations of several Florida psychiatrists that their specialty is being discounted, overlooked or written out of the treatment program. This is simply not true and an explanation of the Committee's position is indicated.

Very simply, we view alcoholism and drug addiction as diseases in the very same sense that diabetes, hepatitis and osteoporosis are diseases although they are different types of disease. Alcoholism and drug addiction do not necessarily indicate a weak will or a psychiatric disturbance.

All other things being equal, the best type of physician to treat addictions is one trained in addictionology. An addictionologist may be a psychiatrist, an internist, a family physi-

cian, or whatever. The field of addiction treatment should be open to such psychiatrists but it is not their exclusive.

Florida Physicians Association

The Report of the Florida Physicians Association, Inc., was adopted.

Florida Physicians Association

David T. Overbey, M.D., President

The Florida Physicians Association was founded in December, 1972, as a non-profit corporation designed primarily to protect the private practice of medicine by undertaking activities that the Florida Medical Association could not enter into because of charter restrictions or legal ramifications which, if pursued, might lead to possible financial damages.

The Florida Physicians Association Board of Directors reviewed the 1981 membership report, and concluded that membership in the Association might be increased if funds were set aside to aid county medical societies with specific problems.

In order to establish such a fund, the annual membership dues were increased from \$15.00 to \$20.00.

Membership dues statements were sent out to each member of the Florida Medical Association inviting them to join the Florida Physicians Association, along with a letter explaining the purpose of the Florida Physicians Association. The additional \$5.00 is being placed in a special fund to assist county medical societies with special problems, as approved by the Florida Physicians Association Board of Directors.

The Board communicated to each county medical society the purpose and use of the dues increase, and members of the Board agreed to make themselves available as speakers at county medical society meetings to explain the need for the Florida Physicians Association. Model editorials are being developed to send to each county medical society for inclusion in their bulletins.

Judicial Council

The Report of the Judicial Council was adopted.

Judicial Council

James A. Winslow Jr., M.D., Chairman

The 1982 Annual Report of the Judicial Council will summarize the major areas of activity that occupied the Council's time since the last Annual Meeting of the Florida Medical Association, held in May of 1981. The Council's duties, functions and composition are specifically prescribed in Paragraph 8, Section 3 of the Florida Medical Association Bylaws.

It is the function of the Judicial Council to direct and supervise the activities of the Association which pertain to questions of medical ethics, descension, and disputes referred to the Association for investigation and adjudication, complaints by patients against members of the Association, and questions of membership and disciplinary action. The Bylaws of the Florida Medical Association further provide that the component county medical societies shall be the basic unit for censuring, suspending, or otherwise disciplining its members. Any member subject to such action has the right to appeal to the Judicial Council in the manner prescribed by the Bylaws.

Since the last Annual Meeting of the Association, the Council has met on the following occasions: April 29, 1981; September 26, 1981; and February 13, 1982. The current membership of the

Council is as follows: James A. Winslow Jr., M.D., Chairman, Tampa, Florida; Joseph H. Davis, M.D., Miami, Florida; O. Frank Agee, M.D., Gainesville, Florida; Robert J. Brennan, M.D., Ft. Lauderdale, Florida; and Maurice H. Laszlo, M.D., North Miami Beach, Florida. The Council has been staffed by Mr. John Thrasher, FMA Legal Counsel.

The Council's activities are summarized under the following headings:

1. **Grievances:** During the past year the Council has continued to handle routine grievances that have been presented to it, pursuant to the Bylaws of this Association. The Council maintained its procedures of allowing county medical societies to resolve these local grievances and report their findings to the individual directly and to this Council. The Council, pursuant to the Bylaws of the Florida Medical Association, retains the right to withdraw these grievances from the local society, if they are not acted upon within a reasonable time. Moreover, in matters involving disputes and descension among members of the county medical societies appropriate Membership and Discipline Committees are utilized as required. Additionally, an individual may appeal a decision of a local county medical society grievance committee to the Council. This system has worked efficiently and the Council encourages each county medical society to process and finalize decisions on the grievances in an efficient, fair and expeditious manner. The Council has recently considered several appeals from decisions of county medical societies relative to disciplinary action taken against physician members. In reviewing these questions, it has been determined that generally speaking, county medical society Bylaws contain the necessary provisions to afford adequate procedural due process to an individual accused of unethical conduct. It is essential that the county medical society not disregard the procedural safeguards enacted in their Bylaws or Constitution. The basic principles of a fair and objective hearing should always be accorded to the physician whose professional conduct is being reviewed. The fundamental aspects of a fair hearing are:

- a. a listing of specific charges;
- b. adequate notice of the right to a hearing;
- c. the opportunity to be present and to rebut the evidence;
- d. the opportunity to present a defense.

These principles apply when the hearing body is a medical society or hospital committee composed of physicians. Medical societies are urged to review their Constitution and Bylaws to insure that these documents provide for such procedural safeguards.

2. **Review of County Medical Society Revisions to Charter and Bylaws:** Pursuant to the Bylaws of the Florida Medical Association, the Bylaws of component medical societies must not be in conflict with those of the FMA. The Council, during the past year has continued to review revisions and amendments to county medical society Charter and Bylaws and encourages county medical societies to timely submit those proposed changes to the Judicial Council for their review.

3. **Opinions of the Judicial Council:** During the past year the Council rendered or adopted the following opinions:

Opinion 82/1: It is the opinion of the Judicial Council that every physician is ethically bound to assist a colleague who is perceived to be impaired. [See Principles of Medical Ethics Number II — "A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception."] It is further the opinion of the Judicial Council that there are a variety of mechanisms available to appropriately meet the various situations of impairment, including, but not limited to the Florida Medical Foundation program for Impaired Physicians.

Opinion 82/2: It is the opinion of the Judicial Council that it is not in the best interest of the public or the profession to charge interest on an unpaid bill, or charge a penalty on fees for professional services not paid within a prescribed period of time. [See Opinions and Reports of the Judicial Council of the American Medical Association, 1981, Number 607].

Opinion 82/3: It is the opinion of the Judicial Council that a physician may ethically charge a service charge for rebilling an unpaid account, provided that the physician has closely scrutinized the time frame for such rebilling as to its reasonableness and that the charge for such rebilling reflects, as closely as possible, the actual expense. [See Opinions and Reports of the Judicial Council of the American Medical Association, 1981, Number 607].

Opinion 82/4: It is the opinion of the Judicial Council that it is not ethical for a physician to require a patient to sign a contract or agreement that provides that the patient shall pay legal fees and court costs should legal action be required to collect a past due account of the patient.

Opinion 82/5: It is the opinion of the Judicial Council that the medical record is a confidential document involving the physician/patient relationship and should not be communicated to a third party without the patient's prior consent, unless it is allowed by law or is necessary to protect the welfare of the individual or the community.

RESOLUTION 82-1

Annual Meeting Site

Lee County Medical Society

The motion of the Reference Committee that Resolution 82-1 be referred to the Board of Governors carried.

RESOLUTION 82-1

Annual Meeting Site

[Not Adopted - Referred to the Board of Governors]

Whereas, There is widespread dissatisfaction with the location of the Annual FMA Meeting; and

Whereas, The use of two or more hotels would not detract from the enjoyment of efficiency of the House of Delegates; and

Whereas, The attendance of the Annual FMA Meeting would most certainly be increased by a change in location; therefore be it

RESOLVED, That the 1983 Annual Meeting of the FMA be held in the Orlando area.

RESOLUTION 82-2

Prohibition Against Smoking

Lee County Medical Society

The Reference Committee moved to amend Resolution 82-2 to include the prohibition of smoking in Reference Committee meetings as well as the meetings of the House of Delegates. The motion to amend carried. Resolution 82-2 was adopted as amended.

RESOLUTION 82-2

Prohibition Against Smoking

RESOLVED, That smoking be prohibited in the meetings of the Reference Committees and the House of Delegates of the FMA.

RESOLUTION 82-3

Awards and Presentations

Lee County Medical Society

Resolution 82-3 was adopted.

RESOLUTION 82-3

Awards and Presentations

RESOLVED, That the *General Session* of the *House of Delegates* of the FMA be extended so that all awards and presentations may be made at the General Session.

RESOLUTION 82-4

Medical Journalism Awards

Lee County Medical Society

Resolution 82-4 was adopted.

RESOLUTION 82-4

Medical Journalism Awards

RESOLVED, That the local county medical society be notified ahead of time if one of the news media in its county is receiving an award; and be it further

RESOLVED, That the representative of the county medical society in the county of the media getting the award be invited to escort the media person to the podium.

RESOLUTION 82-7

Uniform Informed Consent Form

Palm Beach County Medical Society

The Reference Committee Chairman moved that Resolution 82-7 be referred to the Board of Governors. The motion carried.

RESOLUTION 82-7

Uniform Informed Consent Form

[Not Adopted — Referred to the Board of Governors]

Whereas, The surgeons of the State of Florida operate on their patients under the same State and Federal laws; and

Whereas, The definition of informed consent is the same in all counties and hospitals within the State of Florida; and

Whereas, Informing the patient, protecting the patient and surgeon, and protecting the hospitals would not change in principle from hospital to hospital or county to county within Florida; and

Whereas, Having different hospitals develop their own personal forms of informed consent for surgical procedures creates extra legal cost to the hospital, and confusion to the surgeons and patients; and

Whereas, The language of some of these informed consents is legally inadequate; and

Whereas, The Florida Physicians' Insurance Reciprocal has an interest in proper informed consent for the patients and surgeons of the State of Florida; therefore be it

RESOLVED, That the Florida Medical Association in cooperation with the Florida Hospital Association and with legal assistance by the Florida Physicians' Insurance Reciprocal, develop a uniform informed consent form for all hospitals in the State of Florida to be used uniformly for all surgical procedures performed in the State of Florida, and which may be modified from time to time as necessary to comply with new laws.

RESOLUTION 82-8

Mandatory Membership in State

Medical Association

Orange County Medical Society

After considering Resolution 82-8, the Reference Committee reminded the county medical societies that complaints or grievances against non-FMA members may be reported directly to the Department of Professional Regulation.

Resolution 82-8 was not adopted.

RESOLUTION 82-12

Impaired Physician Exemptions

Dade County Medical Association

Resolution 82-12 was adopted.

RESOLUTION 82-12

Impaired Physician Exemptions

RESOLVED, That the FMA Board of Governors strongly recommend to the Board of Medical Examiners that a cooperative program between the Department of Professional Regulations/Board of Medical Examiners and the FMA's Impaired Physicians Program be designed.

RESOLUTION 82-14

Medical Consequences of Nuclear War

Pinellas County Medical Society

Resolution 82-14 was adopted.

RESOLUTION 82-14

Medical Consequences of Nuclear War

RESOLVED, That the Florida Medical Association use its educational and public relations facilities and resources to keep its members and the citizens of Florida informed of the medical consequences of nuclear war.

RESOLUTION 82-17

PIMCO Policies

Osceola County Medical Society

Upon recommendation of the Reference Committee, Resolution 82-17 was not adopted.

RESOLUTION 82-24

Professional Liability Support Fund

Dade County Medical Association

A substitute for Resolution 82-24 was offered by the Reference Committee, and its adoption moved. The motion carried, and Substitute Resolution 82-24 was adopted.

SUBSTITUTE RESOLUTION 82-24 Professional Liability Support Fund

RESOLVED, That each active member of the Florida Medical Association be obligated, if necessary as determined by the Board of Governors, to pay an assessment of \$50.00 in addition to any and all required dues payment; and be it further

RESOLVED, That each physician member of the Florida Medical Association be encouraged to donate \$5.00 to the Florida Medical Political Action Committee as soon as possible.

RESOLUTION 82-26

Binding Arbitration

Dade County Medical Association

Upon recommendation of the Reference Committee, Resolution 82-26 was not adopted.

RESOLUTION 82-27

Assignment of Insurance Benefits

Dade County Medical Association

Upon recommendation of the Reference Committee, Resolution 82-27 was not adopted.

RESOLUTION 82-28

Notification of Third-Party Payments

Dade County Medical Association

Resolution 82-28 was adopted.

RESOLUTION 82-28

Notification of Third-Party Payments

RESOLVED, That the Florida Medical Association solicit the American Medical Association to revise its Uniform Claim Form to include a box item that, when signed by the patient, would instruct third-party payors to provide a copy of the record of payment directly to the physicians.

The Chairman expressed his thanks to each member and alternate member of the Reference Committee for their diligent attention to the business of the House of Delegates. Thanks were conveyed to Mrs. Bonnie Taft, Recording Secretary, and FMA staff members for their support of the Committee, and to the many members of the Association who attended the meeting and presented testimony.

The motion of the Reference Committee that the Report of Reference Committee No. III as a whole be adopted as amended carried.



Frank S. Adamo, M.D., of Tampa, was awarded the Certificate of Merit, FMA's highest honor. Dr. Adamo was not able to be present, and his daughter, Mrs. Mary Frances Robinson of Coral Gables accepted in his behalf.

Dr. Perry, Speaker, called Dr. Sanford A. Mullen to come to the podium to present the Certificate of Merit and Certificate of Appreciation. Dr. Mullen pointed out to the House that the Certificate of Merit is the highest award that can be presented by the FMA. This year's recipient of the award, Dr. Francisco Scozzari Adamo is 89 years old and was unable to attend. His daughter, Mrs. Francis Robertson from Coral Gables was escorted to the podium by Dr. Victor Knight Jr., and Dr. Robert Isbell to accept the award on behalf of her father.

CERTIFICATE OF MERIT

Francisco Scozzari Adamo, M.D.

Whereas, Francisco Scozzari Adamo, M.D., of Tampa, Florida, has rendered distinguished and able service to the medical profession, the citizenry of Florida and the United States of America as a physician for 50 years; and

Whereas, This dedicated physician was born in Tampa, Florida, on January 20, 1893, attended the Chicago College of Medicine and Surgery, and was graduated with an M.D. degree; and

Whereas, This eminent gentleman was associated with Francis Willard Hospital, Children's Hospital, Cook County Hospital and Hillsborough County Hospital; and

Whereas, Dr. Adamo served in the U.S. Army and Army Reserves and was recognized during World War II for his innovative technique in treating gangrene, a common problem for the U.S. wounded troops in tropical regions; and

Whereas, This brave individual was held as a prisoner of war by the Japanese in Bilibid prison for two years; and

Whereas, After returning to the United States following his release, Dr. Adamo was promoted to full Colonel and given the Legion of Merit; and

Whereas, At the age of fifty-one, Dr. Adamo was given a hero's proper welcome when he returned to his hometown of Tampa, Florida, and was honored by the city in changing the name of First Avenue, in the estuary, to Frank Adamo Drive by which it is known today; and

Whereas, Dr. Adamo completed his military service at the Valley Forge Hospital in Pennsylvania and at Ft. Oglethorpe in Georgia; and

Whereas, Upon his discharge he returned to Tampa to resume his medical practice in 1948 which he maintained until his retirement in 1973 after practicing medicine for 50 years; and

Whereas, This leader served as President of Hillsborough County Medical Association in 1955; and

Whereas, Dr. Adamo has given freely of his time and talent to the medical community, the United States of America and the people of the state of Florida; therefore be it

RESOLVED, That a Certificate of Merit be presented to Francisco Scozzari Adamo, M.D., as a token of warm regard and respect that the officers, members and executive staff of the Florida Medical Association hold for the many years of outstanding service rendered by this fine gentleman.

Mrs. Robertson thanked the House for honoring her father.

Dr. Mullen announced that two Certificates of Appreciation had been awarded this year and called upon the representatives of Escambia County to

escort Dr. Geiger to the podium to accept the award on behalf of Dr. Frank Brooks Hodnette, this year's recipient for one of the Certificates of Appreciation.



Frank B. Hodnette, M.D., of Pensacola, was voted an FMA Certificate of Appreciation. Dr. Hodnette was not present to accept, but his Pensacola colleague, Eric Geiger, M.D. (left), accepted the award on his behalf from FMA President Sanford A. Mullen, M.D.

CERTIFICATE OF APPRECIATION

Frank Brooks Hodnette, M.D.

Whereas, Frank Brooks Hodnette, M.D., of Pensacola, Florida, has rendered distinguished and able service to the medical profession and citizenry of Florida since 1945; and

Whereas, This dedicated physician was born in Dadeville, Alabama, on January 31, 1917, attended the Tulane University School of Medicine and was graduated with an M.D. degree; and

Whereas, this able physician is a Fellow of the American College of Surgeons and of the American College of Obstetrics and Gynecology; is a life member of the Escambia County Medical Society and of the Florida Medical Association; and is an active member of the Florida OB-GYN Society, the Pensacola OB-GYN Society, the American Medical Association, the State Advisory Committee for the American College of Surgeons, the State Chapter American College of Surgeons Executive Committee and the Peer Medical Utilization Review Committee; and

Whereas, This eminent gentleman serves on the Board of Directors of Blue Cross/Blue Shield of Florida and was Chairman of the FMA Peer Medical Utilization Review Committee for five years and is Chairman of the Medical Advisory Committee for the Division of Vocational Rehabilitation; and

Whereas, Dr. Hodnette has contributed his time and expertise to many areas of responsibility in the Florida Medical Association by serving on Councils and Committees and special assignments as appointed; therefore be it

RESOLVED, That a Certificate of Appreciation be presented to Frank Brooks Hodnette, M.D., as a token of the warm appreciation that the officers, members and executive staff of the Association hold for the many years of outstanding service rendered by this fine gentleman.

Dr. Geiger, a partner of Dr. Hodnette, accepted the award and thanked the House.

Dr. Mullen called upon Dr. Guy T. Selander to come to the podium to receive the Certificate of Appreciation. Dr. Selander was escorted to the podium by Dr. Faris S. Monsour and Dr. William P. Booras.



Guy T. Selander, M.D., of Jacksonville (left) accepts an FMA Certificate of Appreciation from President Sanford A. Mullen, M.D. Looking on are William P. Booras, M.D. and Faris Monsour, M.D., both of Jacksonville, President and Past President, respectively of the Duval County Medical Society.

CERTIFICATE OF APPRECIATION

Guy T. Selander, M.D.

Whereas, Guy T. Selander, M.D., of Jacksonville, Florida, has rendered distinguished and able service to the medical profession and citizenry of Florida since 1963; and

Whereas, This dedicated physician was born in Summit, New Jersey, on August 2, 1935, attended Maryville College and graduated from Seton Hall University of the New Jersey Medical School with an M.D. degree; and

Whereas, This able physician is an active member of the Duval County Medical Society, the Florida Medical Association, the American Medical Association, the Duval County Academy of Family Practice, the Florida Academy of Family Physicians and the American Academy of Family Physicians; and

Whereas, This eminent gentleman served as President of the Duval County Medical Society in 1977 during which time his leadership was fundamental in developing an interprofessional, community-wide, prescription drug abuse problem program nationally known as the "Duval Plan"; and

Whereas, Dr. Selander is Chairman of the Florida Medical Association Committee on Impaired Physicians which seeks to give impaired physicians professional support and a program on self-help; and

Whereas, Dr. Selander served as a Captain in the United States Army from 1962 through 1964; and

Whereas, Dr. Selander is a member of the Board of Directors of Memorial Hospital and the Florida Palontology Society and is the 1982 Chairman of the Jacksonville Blood Bank; and

Whereas, Dr. Selander has been the recipient of the Editors Award for Best Regular Feature presented by the Florida Medical Association in 1977, the Boss of the Year Award presented by the Greater Duval County Medical Assistants and was awarded a Certificate for Service as Chairman of the "Citizens Committee to Study and Implement Sex Education in Public Schools" presented by the Duval County School Board; and

Whereas, Dr. Selander is Past Secretary-Treasurer and current President-Elect of the Florida Academy of Family Physicians; therefore be it

RESOLVED, That a Certificate of Appreciation be presented to Guy T. Selander, M.D., as a token of the warm appreciation that the officers, members and executive staff of the Association hold for the many years of outstanding service rendered by this fine gentleman.

Dr. Selander, in his acceptance, thanked the House and commended his staff for making the award possible.

Dr. Perry, Speaker, then called upon Dr. Coleman for remarks on this year's FLAMPAC program. Dr. Coleman thanked the House for adopting the report of Reference Committee III and for providing monies that FLAMPAC needs in preparing the political climate for the satisfactory addressing of the professional liability crisis. He noted that, to date, the early 1982 membership enrollment is equal to 1981, a record year. He announced that Medical Action Teams (MAT), a new program this year, established to recruit and train volunteers for participation in individual campaigns this Fall, have been established in 17 target counties. Dr. Coleman re-emphasized FLAMPAC's need for funds and said there is a need to broaden the base of physicians and spouses who are willing to become personally involved and active in individual campaigns. He thanked the officers and staff of the FMA and the House of Delegates for their support and strength. On behalf of the FLAMPAC Board of Governors, Dr. Coleman asked for support of FLAMPAC-endorsed candidates both financially and through individual activities.

The House recessed at 5:05 p.m. to reconvene at 9:00 on Sunday morning, May 9.

Auxiliary Photo Highlights



(1) Mrs. Frank C. Coleman of Tampa, outgoing President of the Auxiliary, and her husband. (2) New officers installed by FMA President Sanford A. Mullen, M.D. (background) are: Mrs. Ferdinando Vizzi, District Vice President (West Central); Mrs. Jack Carver, District Vice President (Southwest); Mrs. V. A. Marks, District Vice President (South); Mrs. James G. White, District Vice President (East Central); Mrs. David S. Whittaker, District Vice President (Northeast); Mrs. Michael Murray, Secretary; Mrs. Rex Orr, Treasurer; and Mrs. Milton Tignor, Treasurer. (3) Mrs. Coleman and her successor as President, Mrs. Daniel B. Nunn. (4) Mrs. Nunn and Dr. Mullen. (5) Mrs. Coleman addresses the FMA-A House. (6) Mrs. Richard B. Moore receives the Peggy Wilcox Award from Mrs. Rex Orr. (7) Mrs. Coleman, Mrs. Nunn, and Mrs. Walter G. Jarrell.

While FMA members were engaged in their 108th Annual Meeting, their spouses were busy with the 54th Annual Meeting of the FMA Auxiliary. *The Journal's* photographer attended some of the sessions and assembled the album that begins on this page.



(8) Dr. Daniel B. Nunn busses the new Auxillary President, Mrs. Nunn (9) Former FMA-A President Edle Epstein. (10) Mrs. Nunn addresses the FMA-A House. (11) Dr. Nunn and children Daniel B., Jr, and Myra. (12) Mrs. Nunn recelves President's Pin from Mrs. Coleman. (13) Mrs. Coleman, Mrs. Henry Harrell, Jr, and Mrs. LaVere White. (14) Dr. William P. Booras, President of Duval County Medical Society, presents Mrs. Nunn with a glft from the Socie-ty. (15) Dr. Mullen Installs Mrs. Nunn as President.



(16) Mrs. Nunn admires a bouquet of flowers presented to her. (17) Mrs. Betty Payne, President-Elect of the American Medical Association Auxiliary addresses the FMA-A House. (18) Mrs. Fred P. Swing presents Mrs. Coleman with her Past President's Pin. (19) Mrs. Tom Birdwell, Mrs. Tom Holmes, Mrs. Eric Gelger, Dr. Jim Potter, Mrs. Joe Salter and Dr. and Mrs. C. Fenner McConnell, all of Escambia County. (20) Dr. and Mrs. Nunn and son Daniel. (21) Dr. and Mrs. Nunn.

Editor's dinner

Editor's of The Journal assembled on Wednesday evening for their annual banquet. JFMA Editor Daniel B. Nunn, M.D. (1) presided at the gathering. The Journal's photographer was there and caught these shots: (2) Historical Editor William M. Straight, M.D., and Scientific Council Chairman and Mrs. Yank D. Coble Jr., M.D., enjoy a light moment. (3) Assistant Editor and Mrs. Edward Pedrero, M.D., pay close attention to the program. (4) Associate Editor Clyde M. Collins, M.D., was in his usual good mood. (5) JFMA Editorial Assistant Kathy Lundy, Duval County Medical Society Executive Vice President Ernest Currie and Mrs. William P. Booras. (6) Dr. Nunn presents Assistant Editor Frank C. Coleman, M.D., with a bound volume containing all 1981 issues of JFMA. (7) Dr. Nunn presents JFMA Executive Editor Edward D. Hagan with a picture taken at a previous meeting. (8) Miss Myra Nunn and Miss Cindy Jarrell.



Third House of Delegates

The third meeting of the House of Delegates convened at 9:00 a.m. on Sunday, May 9, 1982, in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, with the Speaker of the House, Dr. James B. Perry, presiding.

Richard A. Bagby, M.D., Co-chairman of the Credentials Committee, reported that 228 Delegates were registered, representing 45 county societies, which constituted a quorum, and moved that the delegates be seated. The motion carried.

Delegates

ALACHUA—O. Frank Agee, M.D.; Raymond H. Alexander, M.D.; William B. Deal, M.D.; Charles P. Gibbs, M.D.; Douglas O. Jenkins, M.D. (Absent—Mark V. Barrow, M.D.; Student, Diane M. Zabak.)

BAY—James T. Cook III, M.D. (Absent—Terrence R. Steiner, M.D.)

BREVARD—James E. Carter, M.D.; Walter A. Cerrato, M.D.; Michael J. Foley, M.D.; Francis S. Pooser, M.D.; Paul J. Popovich, M.D.; (Absent—Ovidio E. Vitas, M.D.)

BROWARD—Robert L. Berger, M.D.; Anna M. Blenke, M.D.; Andre S. Capi, M.D.; Phillip A. Caruso, M.D.; David A. d'Alessandro, M.D.; Arthur L. Eberly, M.D.; Kenneth H. Farrell, M.D.; Paul A. Flaten, M.D.; William C. Hartley, M.D.; Wilbur F. Helmus, M.D.; David C. Lane, M.D.; Robert J. Lenar, M.D.; George P. Messenger, M.D.; Alexander E. Molchan, M.D.; Jerry D. Moore, M.D.; Donald J. Plevy, M.D.; Thomas F. Regan, M.D.; Ernest G. Sayfie, M.D.; Herbert M. Todd, M.D.; Anthony J. Vento, M.D. (Absent—Robert J. Brennan, M.D.; Stanley S. Goodman, M.D.; John M. Harper, M.D.; Joseph M. Sachs, M.D.; Richard D. Schultz, M.D.; Richard D. Shafron, M.D.; Peter A. Tomasello, M.D.; Juan S. Wester, M.D.)

CAPITAL—Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Robert N. Webster, M.D.

CHARLOTTE—Thomas R. Civitella, M.D.; Jaime Torner, M.D. (Absent—Joseph R. Goggin, M.D.)

CITRUS—HERNANDO—Wilburn R. Jenkins, M.D.; Clinton J. McGrew, M.D.

CLAY—(Absent—Hinson L. Stephens, M.D.)

COLLIER—Charles J. Montgomery, M.D.; Virgil A. Ponzoli Jr., M.D.; Joseph F. Sullivan, M.D.

COLUMBIA—Barney E. McRae, M.D.

DADE—Edward R. Annis, M.D.; Jerome Benson, M.D.; Robert E. Boyett, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; Edmund Cava, M.D.; Richard C. Clay, M.D.; Vincent P. Corso, M.D.; DeWitt C. Daughtry, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Charles A. Dunn, M.D.; Augusto Fernandez-Conde, M.D.; Miguel Figueroa, M.D.; N. Ralph Frankel, M.D.; George R. Gage, M.D.; Richard L. Glatzer, M.D.; Julian H. Groff, M.D.; Joseph Harris, M.D.; Walter C. Jones III, M.D.; Herbert S. Kaiser, M.D.; Norman M. Kenyon, M.D.; Warren Lindau, M.D.;

Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Robert L. Maury, M.D.; William T. Mixson, M.D.; Charles A. Monnin Jr., M.D.; Miguel A. Mora, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Jorge R. Pena, M.D.; Pedro A. Ramos, M.D.; William I. Roth, M.D.; Walter W. Sackett, M.D.; Daniel L. Seckinger, M.D.; Everett Shocket, M.D.; M. David Sims, M.D.; Margaret C. S. Skinner, M.D.; Douglas Slavin, M.D.; Marvin B. Slotkin, M.D.; Samuel P. Stokley, M.D.; Charles F. Tate, M.D.; John C. Turner, M.D.; Thomas B. Turner, M.D.; Osvaldo D. Valdes, M.D.; Edgar W. Webb, M.D.; Harold H. Weiner, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D.; Student, James E. Deming. (Absent—Victor O. Calderin, M.D.; William P. Calvert, M.D.; Alan S. Graubert, M.D.; Melvin A. Klein, M.D.; Steven M. Weissberg, M.D.; Bruce W. Weissman, M.D.; Leo Whitman, M.D.)

DESOTO—HARDEE—GLADES—Calvin W. Martin, M.D.

DUVAL—Gaston J. Acosta-Rua, M.D.; Samuel J. Alford Jr., M.D.; Mohamed H. Antar, M.D.; William P. Booras, M.D.; Yank D. Coble, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; William J. Garoni Jr., M.D.; Charles P. Hayes Jr., M.D.; Benjamin A. Johnson, M.D.; Charles W. Lewis, M.D.; John F. Lovejoy Jr., M.D.; Faris S. Monsour, M.D.; Daniel B. Nunn, M.D.; Guy T. Selander, M.D.; Paul D. Shirley, M.D.; Robert H. Threlkel, M.D.; James W. Walker, M.D.; William D. Walkett, M.D.

ESCAMBIA—Richard H. Ciordia, M.D.; Eric F. Geiger, M.D.; Charles J. Kahn, M.D.; Theodore J. Marshall, M.D.; Charles F. McConnell, M.D.; F. Norman Vickers, M.D.

FLAGLER—(Absent—John M. Canakaris, M.D.)

FRANKLIN—GULF—Joseph P. Hendrix, M.D.

HIGHLANDS—(Absent—Luis M. Pena, M.D.; Robert T. Rengarts, M.D.)

HILLSBOROUGH—Richard A. Bagby, M.D.; Frank C. Coleman, M.D.; Richard G. Connar, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Richard S. Hodes, M.D.; Robert G. Isbell, M.D.; Victor H. Knight Jr., M.D.; Thomas E. McKell, M.D.; Robert E. McCammon, M.D.; Robert J. Qualey, M.D.; Ralph E. Rydell, M.D.; Ronald L. Seeley, M.D.; William M. Trice, M.D.; James A. Winslow Jr., M.D. (Absent—Emilio D. Echevarria, M.D.; Student, Alexander S. Gross.)

INDIAN RIVER—(Absent—Donald L. Ames, M.D.; Paul Graham, M.D.)

LAKE—Frederick C. Andrews, M.D.; Joseph E. Holland, M.D.; Robert H. Hux, M.D.

LEE—Cecil C. Beehler, M.D.; Larry P. Garrett, M.D.; Francis L. Howington, M.D.; H. Quillian Jones Jr., M.D.; Stephen R. Zellner, M.D.

MADISON—(Absent—William J. Bibb, M.D.)

MANATEE—Thomas R. Busard, M.D.; George C. Gallati, M.D.; Julian Giraldo, M.D.; Michael G. Ryan, M.D.

MARION—C. Brooks Henderson, M.D.; James L. McLaughlin, M.D.; Samuel L. Renfroe, M.D.

MARTIN—Fred S. Carter, M.D.; Guy R. Hopper, M.D.

MONROE—Ronald H. Chase, M.D. (Absent—Robert D. Carraway, M.D.)

NASSAU—(Absent—E. Trier Morch, M.D.)

OKALOOSA—David R. Arrowsmith, M.D.; Samuel M. Atkinson Jr., M.D.

ORANGE—Edward Ackerman, M.D.; Clarence M. Gilbert, M.D.; William E. Hoffmeister, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.;

Charles T. Price, M.D.; James F. Richards Jr, M.D.; Robert N. Serros, M.D.; Edward W. Stoner, M.D.; John P. Taggart, M.D.; T. Byron Thames, M.D.; Cecil B. Wilson, M.D. (Absent—Robert B. Trumbo, M.D.)

OSCEOLA—Gilberto Perez, M.D.

PALM BEACH—Vernon B. Astler, M.D.; Elizabeth J. Barice, M.D.; Richard C. Cavanagh, M.D.; Ralph R. Eastridge, M.D.; Lee A. Fischer, M.D.; J. Russell Forlaw, M.D.; Luis R. Guerrero, M.D.; James M. Johnson, M.D.; V. A. Marks, M.D.; Richard B. Moore, M.D.; William J. Romanos Jr., M.D.; James F. Smith, M.D.; Joel F. Smith, M.D.; Milton R. Tignor Jr., M.D.; Dick L. Van Eldik, M.D. (Absent—Ben R. Thebaut Jr., M.D.)

PANHANDLE—James T. Cook Jr., M.D.; Karl S. Franz, M.D.

PASCO—Kong D. L. Chiang, M.D.; David A. Johnson, M.D. (Absent—Vincent G. Cotroneo, M.D.)

PINELLAS—Robert L. Dawson, M.D.; Michael H. Diamond, M.D.; Charles K. Donegan, M.D.; John M. Hamilton, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; Morris J. LeVine, M.D.; Jack A. MacCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; William H. Schmid, M.D.; Bruce P. Smith, M.D. (Absent—Thomas M. Daniel, M.D.; John M. Thompson, M.D.; Walter H. Winchester, M.D.)

POLK—Ronald W. Case, M.D.; Thomas M. Caswall, M.D.; John W. Glotfelty, M.D.; Thomas E. McMicken, M.D.; John C. Moore, M.D. (Absent—Saul B. Gerber, M.D.; Wiley E. Koon, M.D.; David Stoler, M.D.)

PUTNAM—(Absent—Roy E. Campbell, M.D.)

ST. LUCIE-OKEECHOBEE—William H. Meyer Jr., M.D. (Absent—Charles R. Cambron, M.D.)

SANTA ROSA—David B. Young, M.D.

SARASOTA—John N. Carlson, M.D.; Kenneth C. Kiehl, M.D.; Martin F. Mihm, M.D.; Douglas R. Murphy, M.D.; Franklin H. Pfeifferberger, M.D.; Richard C. Rehmyer, M.D.; Karl R. Rolls, M.D.

SEMINOLE—Luis M. Perez, M.D.; Frederick J. Weigand, M.D.

SUWANNEE-HAMILTON-LAFAYETTE—(Absent—Alex Kish, M.D.)

TAYLOR—(Absent—John H. Parker, M.D.)

VOLUSIA—Grandy B. Barnard, M.D.; Charles R. DeArmas Jr., M.D.; Remigio G. Lacsamana, M.D.; Robert W. Lankford, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.

WALTON—(Absent—Howard F. Currie, M.D.)

WASHINGTON—(Absent—Muhammad I. Zafar, M.D.)

SPEAKER OF THE HOUSE—James B. Perry, M.D.

VICE SPEAKER—Franklin B. McKechnie, M.D.

Installation of the President

Dr. Perry recognized the President, Dr. Sanford A. Mullen, and asked that he come forward to install the new President.

Drs. Douglas R. Murphy and Martin F. Mihm, both of Sarasota, escorted Dr. Robert E. Windom to the podium while Dr. Karl R. Rolls, also of Sarasota, made some pertinent remarks about the new President.

Dr. Mullen then presented the personal gavel and President's certificate along with a new token, a book entitled "Familiar Medical Quotations" to Dr. Windom, the new President.

Dr. Windom presented Dr. Mullen with the Past President's Pin and asked Mrs. Mullen to come

to the podium. Mrs. Mullen was escorted by her sons, Henry, Michael and Allen and daughter-in-law, Lynn, to the platform, where she was presented with Dr. Mullen's portrait.

Remarks of the President

The agenda reads "Remarks of the President." So I will take advantage of the opportunity to make a few remarks at this time. Again, I can't tell you how pleased I am to be here. I would like to introduce to you at this time four people whose love and devotion has made it possible for me to obtain this position: my wife, Lelia, and my sons Bob, Ross, and Hugh.

In 1970, I attended my first House of Delegates meeting as a guest while down here for the Society of Internal Medicine meeting. I ran into some of my colleagues from home and during our conversation, they said "Bob, you ought to come in and see what the real organization of medicine does." I attended that House of Delegates meeting as a guest and was impressed with what I observed. Dr. John Butcher from Sarasota said to me, "Bob, you ought to be President of the organization some time." I replied, "John, there is no way! I've been involved for a number of years in the Heart Association and that's where I am now, but I will support this group." But again, things have changed. In 1972, President Bill Dean appointed me to the Chairmanship of the Council on Voluntary Health Agencies which started my enthusiastic progression through this organization.

I am grateful to them and to my delegation comprised of distinguished colleagues from home. They have been strong supporters of organized medicine.

I am assuming this position with great confidence that I am going to be working with a staff second to none in the United States. I am confident that our staff is behind us working daily for our good cause. The support and association of the past and current leaders, including officers, delegates and committee chairmen makes our structure second to none.

This week we have heard comments that we are a family. In his Presidential Address Wednesday, Dr. Mullen spoke of the unity of our family. In the last several years, we have seen fragmentation from outsiders who think they are physicians or authorities in medicine but who are not. This fragmentation is something we must be concerned about.

On Friday at the Baldwin Lecture our family history was again recalled. It was noted that Dr. Abel Baldwin founded both the FMA and the Duval County Medical Society. Our House, our organization of medicine, really became official and strengthened in its scientific endeavors in 1910

when the Flexner Report was adopted, establishing a basis of scientific and educational excellence which we continue to follow.

As I look at the House of Medicine, I look at the foundation, the floor, which I visualize as being made up of our county medical societies. The walls of our House I consider to be the state organization. We have a House of very strong walls.

However, as we look at our roof—representing the AMA—we find that about 50 percent of the shingles are missing today. This is a result of fragmentation within our membership throughout the country. Half our members are carrying the load in maintaining the strength of that roof and if that roof gets weaker, no matter how strong the walls and floor are, the House will gradually deteriorate. I would be presumptuous to assume that within the next 12 months I am going to get 100 percent shingle replacement. However, I hope you will join me, with each day and week that passes, in doing all we can to get our colleagues to become a part of that roof as members of the AMA so that the whole House of Medicine will be unified and stronger.

We are going to have problems, as we have every year, but as a group, we can work in a unified way and speak as one. Solve our problems within the House as you do in your own home. We have in our homes, divergence of opinion and dissension at times. But, I feel that within the organization of our own family, we can unite and overcome these minimal obstacles.

You have heard that I am concerned about community involvement which Dr. Sanford Mullen had as his theme last year. I hope all of us will continue our community efforts and realize that we are not just doctors, but vital parts of every town and city of

this country. Our participation in the actions of our local government and our service to our community through other organizations are very important and we should assume leadership roles in those areas as we do in medicine.

I am looking forward to a year of excitement and I certainly hope that you will join me here next year to count our successes. We must keep our House of Medicine as strong as it can be for those who follow us, for that House was there before we entered it and it will be there after we leave it. But like our own family, I hope that we will look to the future of those who follow us so that the profession, the discipline of medicine, will be great for generations to come.

Thank you very much.



One of the highlights of the final session of the House of Delegates was the presentation of outgoing President Sanford A. Mullen's portrait to his family. Left to right: sons Michael H. Mullen and Henry W. Mullen; Mrs. Sanford A. Mullen; Mrs. S. Allen Mullen Jr; Dr. Mullen Jr; and the retiring President.

Change of Command



One of the highlights of the third session of the House of Delegates was the installation of the new President, Robert E. Windom, M.D. The first step (upper left) was the presentation of the gavel by outgoing President Sanford A. Mullen, M.D., to Dr. Windom. Next, the President's Certificate was presented to the new President (upper right). Then, the new President received a copy of "Familiar Medical Quotations" (lower left). Finally, Dr. Windom reciprocated by presenting Dr. Mullen with his Past President's Pin (lower right).

Report of Reference Committee No. IV

Legislation and Miscellaneous

Dr. Edward Ackerman, Chairman, and his Committee came forward to present the report of Reference Committee No. IV — Legislation and Miscellaneous.

The Reference Committee considered the items referred to it and heard testimony from members of the Florida Medical Association about them.

The Reference Committee expressed public commendation to Dr. Louis Murray for his outstanding work in his role as Chairman of the Council on Legislation and Dr. Frank Coleman as Vice Chairman of the Council on Legislation. The Committee also expressed their wish to commend Mr. Donald S. (Scotty) Fraser, Jr, Associate Executive Director; Mr. George S. Palmer, Jr, Assistant Director of Legislative Affairs; Mr. Jim McCloy, Assistant Director of Legislative Affairs; and to all other FMA staff members who worked on the legislative program. The Reference Committee also wished to recognize the contributions of all members of the Florida Medical Association who had participated in FMA legislative activities during the past year, and commended the Capital Office of the Florida Medical Association for the outstanding "Legislative Bulletin", enabling all Florida Medical Association members to have timely information on legislation and legislative problems.

Report D of the Board of Governors

Report D of the Board of Governors was adopted.

Report D of the Board of Governors Sanford A. Mullen, M.D., Chairman

Board Actions of Major Importance

FLAMPAC

Membership — The Board applauded the achievements of FLAMPAC and the increase in members which reached an all-time high during 1981. The Board urged continued and expanded interest on the part of physicians and their spouses in the political process and active participation in FLAMPAC activities particularly because of legislative reapportionment and congressional redistricting during 1982 and the dramatic impact this will have on the 1982 elections.

Voter Registration — The Board expressed support for the joint FLAMPAC/County Medical Society efforts to register physicians and their spouses to vote and to urge them to vote in the 1982 elections.



Reference Committee IV held hearings on reports and resolutions dealing with Legislation and Miscellaneous. Left to right: Robert E. Boyett, M.D.; Faris S. Monsour, M.D.; Edward Ackerman, M.D., Chairman; Ms. Helen Bradford, Recorder; Kenneth C. Kiehl, M.D.; and Hector R. Mendez, M.D.

Board of Directors — The Board approved the appointment of Dr. Robert E. Windom, FMA President-Elect, as a regular member of the FLAMPAC Board of Directors and Mrs. Nancy Corwin of Jacksonville as an additional Auxiliary member to the Board. Dr. Luis M. Perez, FMA Secretary, was appointed as the FMA Board of Governors representative on the FLAMPAC Board.

Local Support Committees — The Board approved an amendment to the FLAMPAC bylaws to provide for creation of local FLAMPAC support committees.

FMA Councils and Committees

COUNCIL ON LEGISLATION

1981 Legislative Session — The Board expressed its sincere appreciation and commendations to the members of the Committee on State Legislation, and the many individual physicians and members of the FMA Auxiliary who contributed their time and efforts in helping to achieve the Association's objectives during the 1981 Legislative Session.

Legislative proposals which FMA **opposed** that were defeated by the Legislature included:

- Use of drugs by optometrists.
- Access to hospital facilities by chiropractors.
- Subsidy for state employees enrolling in HMO's.
- Rewrite of physical therapy act which included elimination of requirement for a physician prescription for physical therapy services.
- Mandated use of problem-oriented medical records.
- Elimination of current criteria for issuance of temporary and limited medical licenses.
- State takeover of county health units.
- Licensure of homeopathic physicians.
- Establishment of a school of chiropractic.
- "Freedom of Choice" for employees in Workers' Compensation Program.
- Interest on judgements to be assessed from date claim arose.
- State funding for HSA's and SHCC.
- Licensure of naturopathic physicians.

The FMA **supported** legislation which was enacted that gave expanded authority to the State Board of Medical Examiners, including:

- Authority for Board to hire legal counsel.
- Authority for Board to establish criteria for investigators.
- Greater responsibility for Board in approving budgets.
- Requirement that a physician be notified of changes and that complaints be in writing.

In addition, the Florida law on cytologic and breast exams to patients in hospitals was repealed and legislation establishing children's cancer programs and treatment centers was enacted. The Medical Malpractice Joint Underwriting Association (JUA) was also re-enacted.

Legislation that the FMA was **opposed** to that passed, included:

- Licensure of psychologists and other mental health professionals.
- Requirement that physicians respond to the question of whether they will accept Medicare assignment on licensure renewal.
- Authorization for use of unconventional therapies to treat cancer.
- Authority to allow chiropractors to certify school children to be exempt from communicable disease immunization requirement.
- Expansion of the wrongful death act.

1982 Legislative Session — The 1982 Session of the Florida Legislature convened three months early on January 18, 1982. Dominant issues included Sunset Review of the State Insurance Code and Hospital Licensure Law, legislative reapportionment and congressional redistricting. At the time of this writing, the legislature had not completed its work by the official end of the session on March 18 and extended the session until March 25. The Governor called a special three-day session to deal with reapportionment and will call subsequent sessions to address other unfinished business of the legislature.

The following is a summary of the FMA legislative priorities during the 1982 session. The final action of the legislature on each of these issues will be summarized in a supplemental report of the Council on Legislation which will be included in the delegates packet.

Support for Legislation:

- Support efforts to sustain Governor Graham's veto of the I.A.T. bill (CS/SB 747) the unorthodox Cancer Treatment bill and requested the President to send a letter to all FMA members urging that they contact their individual legislators to seek their support for sustaining the Governor's veto and further that the FMA's position on the bill be widely disseminated through the news media.
- Sponsor legislation requiring filing of written protocols with the State Board of Medical Examiners and appropriate physician supervision for Advanced Registered Nurse Practitioners.
- Require use of seat restraints in cars for infants four years of age and younger.
- Continue Community Hospital Education Council (CHEC) in essentially its present form.
- Modify current hospital cost containment law to eliminate tie-in with health planning and to simplify reporting requirements.
- Expansion of child abuse treatment team program to all Department of Health and Rehabilitative Services' districts.
- Make methaqualone unprescribable in Florida.
- Require that proof of licensure must be submitted with application for occupational license.
- Support for increased funding for the perinatal program, provided that suitable FMA policy is developed on this issue (now under study by the Council on Specialty Medicine).
- Monitor Sunset review of the State Insurance Code and Hospital Licensure Law.

Opposition to:

- The use or prescribing of drugs by optometrists in treating disease.
- State funding of HSA's.
- Access to hospital staff privileges or facilities for chiropractors.
- Future state funding of the School of Osteopathy in Florida.
- Access to hospital facilities or services by chiropractors.
- State funding of HSA's.
- Statutory recognition for chiropractors to certify disability of patients on equal status to M.D.'s and D.O.'s.
- Make Hospital Cost Containment Board rate regulatory or include physicians under jurisdiction.
- Funding for School of Osteopathy.
- Funding for School of Optometry.
- Licensure of homeopathic physicians.
- Licensure of naturopathic physicians.
- Mandatory insurance coverage for chiropractors.
- Mandatory insurance coverage for psychologists.
- Licensure of outpatient emergency clinics under the Hospital Licensure Law.
- Mandatory inclusion of chiropractic services in HMO's.
- Mandatory inclusion of chiropractic services in self-insurance programs.

- Prohibition against insurance companies using an M.D. or D.O. to do an independent exam of a patient to determine if continued chiropractic treatment is appropriate.

Public Health Training Programs — Expressed support for the concept of expansion of current training programs for public health professionals.

Bloc Grants — Directed that the FMA made every effort to insure that state administered health programs receive the highest level of funding possible.

PLI Crisis — Resolution of the professional liability insurance problem in Florida remains a vital and top priority of the FMA. The report and recommendations of the Committee on PLI, adopted by the Board in October 1981, (reprinted in the November issue of *The Journal*) contains an indepth analysis of the problem, as well as an outline of some of the actions that have been taken, as well as future efforts to resolve this critical problem in the most effective and expeditious manner possible. This report, which is included as an enclosure to the *Delegates Handbook*, should be carefully reviewed.

Council on Legislation

The Report of the Council on Legislation was adopted.

Council on Legislation

Louis C. Murray, M.D., Chairman

Most of the work of the Council on Legislation is accomplished through activities of its two committees: the Committee on State Legislation and the Committee on National Legislation. The report of your Council is submitted as individual reports of the two major committees.

Committee on National Legislation

This Committee consists of the key contact physicians for each member of the Florida delegation of the U.S. Senate and the U.S. House of Representatives. Members of this Committee have kept in close touch with their assigned senators and congressmen on national legislative matters of interest to the FMA and American Medical Association.

The Association has maintained active liaison with members of the Florida Congressional Delegation on key legislative issues. Numerous conferences in Washington between FMA staff, key contact physicians and selected congressmen were necessary in order to carry out FMA and AMA policies on these issues. In addition to these individual visits, a comprehensive visitation was conducted by FMA key contact physicians and officers with the two U.S. senators and house members who served on committees with jurisdiction over key health issues. This continuing personal liaison resulted in excellent cooperation from Florida's delegation.

The issues that necessitated major action by the FMA and contact physicians were:

- Support for efforts to phase out federal funding for PSRO's and HSA's.
- Support for legislation to prohibit the FTC from taking action against state-regulated professions and their organizations.
- Support for efforts to repeal the current federal legislation on HSA's and health planning.
- Monitoring of federal budget cuts and bloc grant proposals.

The Ninety-Seventh Congress, 2nd Session, promises to be increasingly active in federal health legislation. Among the key issues that will be considered that are of particular interest to the FMA are:

- Repeal of HSA and National Health Planning Law.

- Monitoring of federal proposals on "competition" and taking appropriate action in coordination with the AMA Washington Office to defeat portions of these that would increase government regulation of the delivery of medical care.
- Support legislation to prevent the FTC from taking action against state-regulated professions or their state or national organizations.
- Monitoring of congressional deliberations on health portions of President Reagan's budget.
- Continue opposition to PSRO's.

This will require the Association to continue to maintain close liaison with Florida's Congressional Delegation and with the AMA Washington Office.

Committee on State Legislation

The Committee has had another active year with responsibilities for coordinating all state legislation for the Florida Medical Association and recognized specialty groups. Four formal meetings of the Committee have been held, along with informal conferences among Committee members as items of an urgent nature arose.

Consistent with the policies developed by the FMA House of Delegates, the Committee has worked closely with the Board of Governors in developing our legislative program for the 1982 Session of the Florida Legislature.

The following items summarize the Committee's activities:

1. The legislative program is continuing to function under the supervision of Donald S. Fraser Jr., Associate Executive Director. He has been materially assisted by Mrs. Nancy Moreau, Legislative Analyst; George S. Palmer Jr., Assistant Director of Legislative Affairs; and Jim McCloy, Assistant Director of Legislative Affairs. Particularly helpful to the legislative activity has been the FMA Branch Offices. These have greatly increased the Association's ability to maintain liaison with county medical societies, contact physicians and members of the Legislature.
2. The Capitol Dispensary. The Committee placed major emphasis on working with the Capitol Dispensary which has proven to be most important in meeting the needs of legislators and their staffs. Mrs. Delma Hart, R.N., has continued to provide excellent assistance to the FMA in coordinating the activities of the Dispensary for the Doctor of the Day program.
3. The Committee on State Legislation is continuing to emphasize the need to develop a good key contact physician program in each county medical society in the state. In addition, priority attention has been directed toward increasing the role of the Auxiliary in the Association's efforts.
4. Publications. A *Legislative Bulletin* was published every week during the legislative session and periodically between sessions. The bulletin is designed to give up-to-date information to members of the FMA who are involved in legislative activities. A listing of all bills monitored by the Capital Office is sent on a regular basis to county medical society executives and legislative chairmen. In addition, summaries and copies of key legislative proposals are distributed. Legislative manuals have been published and distributed to key physicians and Auxiliary leaders, and each key contact physician has been given a specially designed notebook for either state or national legislation.
5. 1981 Legislative Accomplishments. During the 1981 legislative session, there were more than 300 legislative proposals that required action by the State Legislative Committee or the Capital Office staff. Matters of major interest to the Florida Medical Association were:

- Passage of funding authorization to allow the Florida Medical Foundation to provide medical direction and long-range planning for Florida's Emergency Medical Services program.

- Passage of legislation to continue Florida's Medical Malpractice Joint Underwriting Association (JUA).
- Passage of legislation to repeal the mandatory pap smear and breast examination law.

Defeat of the following legislative proposals:

- Use of drugs by optometrists (SB 349, HB 482).
 - Subsidy for state employees enrolling in HMO's.
 - State takeover of county health units (SB 162).
 - Hospital privileges for chiropractors (HB 242).
 - Licensure of homeopathic physicians (HB 49).
 - Lowering of medical licensure standards.
 - Licensure of naturopathic physicians (HB 830).
 - Mandatory inclusion of chiropractic services in HMO's.
 - State funding of HSA's.
6. Major Legislative Priorities for 1982 Session. The major legislative objectives, as of the date of this report, for the 1982 Session of the Florida Legislature as developed by the FMA House of Delegates and the Board of Governors are:
- Pass legislation relating to physician supervision of Advanced Registered Nurse Practitioners.
 - Continue statutory authority for strong medical staff role in the determination of privileges and discipline of staff members.
 - Reenactment of Florida's current Emergency Medical Services Law.
 - Sustain Governor Graham's veto of the I.A.T. cancer treatment bill passed in the 1981 session (CS/HB 747).
 - Modification of current Hospital Cost Containment Board law to eliminate tie-in with HSA's and to simplify data reporting requirements.
 - Pass legislation to require use of seat restraints in cars for infants.

Devote priority attention to defeat the following proposals:

- Authorization for optometrists to use drugs.
- Access to hospital facilities by chiropractors.
- Recognition for chiropractors to certify disability on equal status to M.D.'s and D.O.'s.
- State funding of HSA's.
- Authorization for Hospital Cost Containment Board to review physician charges.
- Mandatory insurance coverage for chiropractors, psychologists and social workers.
- Licensure of homeopathic physicians.
- State takeover of county health units.
- Subsidy of state employees enrolling in HMO's.
- Requirement for filing by physicians of financial interest in health care facilities.
- Expansion of authority of HSA's to require establishment of local efforts to promote competition in health care.

A supplemental report will be prepared by the Committee on State Legislation and distributed prior to the first session of the House of Delegates. This supplemental report will outline up-to-date progress of the FMA legislative program made during the 1982 Legislative Session. It will also include other important state legislative items which might develop prior to the FMA Annual Meeting.

Supplemental Report

The Supplemental Report of the Council on Legislation was adopted.

Supplemental Report Council on Legislation

This is to update the report of the Council on Legislation printed in the *House of Delegates Handbook*. This report reflects the status of legislation as of April 12, 1982.

Priority Supported by the FMA That Passed Include:

- Physician supervision of Advanced Registered Nurse Practitioners in the performance of medical acts (CS/CS/HB 239).
- Local Health Council Legislation and re-enactment of the Hospital Licensure Law (Chapter 395, Part I) and the Florida Hospital Cost Containment Board (Chapter 395, Chapter II); (CS/HB 931).
- Vehicle seat restraint devices for infants four years of age and younger (CS/SB 298).
- Food, Drug and Cosmetic Act, revising Chapter 500, passed on April 7th during the sixth special session and will be sent to the Governor for signature.
- Continuance of statutory role of medical staff in determination of hospital privileges and discipline of staff members.

Major Issues Successfully Opposed by the FMA Include:

- Licensure of Homeopathic Physicians (HB 140, SB 621).
- State funding of HSA's (SB 683, HB 211).
- Bringing hospital-based physicians under the jurisdiction of the Hospital Cost Containment Board.
- Establishment of coalitions for competition in health care to replace HSA's.
- Mandatory disclosure of financial interests in health care facilities (HB 733, SB 380).
- Optometry drug bill (HB 909, SB 901).
- Hospital staff privileges for chiropractors.
- State takeover of county health departments.

Other Significant Issues on which FMA Positions were Sustained:

- Defeat of the proposed rewrite of the license law for physical therapists (SB 234, HB 538).
- Opposition to granting automatic hospital privileges to all licensed physicians (HB 830).
- Opposition to lowering education requirements for licensure of marriage and family therapists (HB 300).
- Opposition to hospital licensing based on degree of cross-subsidization (HB 792).
- Support of recruitment of family doctors for medically underserved areas (HB 1024).
- Maintain sales tax exemption for professional services.
- Authorization for treatment of minors without parental consent who are victims of sexual battery (SB 622, HB 755).
- Authorization for pharmacists to fill prescriptions from outside Florida (SB 759, HB 865).
- Immunity for physicians, nurses and others in reporting excessive prisoner abuse (HB 1086).

Other Legislation of Interest to FMA and Auxiliary Members That Passed:

- Perinatal Program revisions and establishment of the Infant Hearing Impairment Program (SB 731).

- Transfer of methaqualone from Schedule II to Schedule I (SB 100).
- Authority granted to the Department of Professional Regulation to obtain patient records pursuant to a subpoena without patient authorization for drug investigations (SB 459).
- Payment of medical expenses by the Bureau of Crimes Compensation for examination of victims of sexual battery (SB 166).
- Extension for another year of the Medicaid Hospital Out-patient Services Pilot Project (SB 279).
- Designation of the Department of Health and Rehabilitative Services to verify that trauma centers comply with current medical standards (SB 490).
- Authorization for the Department of Health and Rehabilitative Services to recover payments from providers for certain Medicaid services (SB 583).
- Provision of certain exemptions to the Public Records Law for the Department of Health and Rehabilitative Services when investigating Medicaid fraud and abuse (SB 636).
- Prohibition of the Department of Health and Rehabilitative Services from adopting rules governing certain hospices (SB 672).
- Establishment of a comprehensive state plan for the prevention of child abuse and neglect (HB 296).
- Exemption from educational requirements for certification in Acupuncture (HB 615).
- Revision of criteria for admission of minors to state mental institutions (HB 665).
- Requirement for criteria for disposal of infectious waste by hospitals (HB 766).
- Establishment of criteria for licensure and practice of lay midwives (SB 630).
- Authorization for the use of blood fractions (I.A.T.) for cancer treatment in Florida (CS/HB 747) by virtue of Governor Graham's veto being overridden.

Several items of specific interest to medicine were included in the rewrite of the Florida Insurance Code:

Patient's Compensation Fund:

1. Limited liability coverage of \$5,000,000 or \$10,000,000 will be offered by the PCF.
2. The PCF shall not be responsible for payment of punitive damages awarded for damages by health care providers.
3. The \$100,000 limitation of liability schedule is increased:
 - ... to \$150,000, July 1, 1983
 - ... to \$200,000, July 1, 1986
 - ... to \$250,000, July 1, 1989
4. The \$15,000,000 cap is removed.
5. The PCF fees shall be based on three instead of two geographical areas, and on five categories of practice instead of three.
6. The PCF may adjust fees on an individual member basis to reflect the claims experience of each member.
7. Assessments cannot exceed two times the original fee.
8. The PCF can borrow between years.
9. Risk management is required for institutions covered by the PCF.

Disability Certification by Chiropractors

- No determination of disability shall be rejected solely on the basis of a physician's practice act and scope of practice. The carrier has the option to seek a second physician's opinion prior to paying additional benefits.

Optional Coverage for Chiropractic Services

- Retains current law which states coverage for chiropractic services can be provided, if requested by the insured or subscriber under an individual policy or subscriber under a master policy, at an additional premium.

Direct Payment to Hospitals

- Continues policy of allowing direct payment of benefits direct to any recognized hospital or physician.

Coverage of Newborn Children

- Provides that health insurance benefits applicable for children shall be payable with respect to a newborn child of the insured or subscriber from the moment of birth.

Standard Health Claim Form

- The Department of Insurance shall prescribe a claim form to be used by all hospitals, physicians, dentists, and pharmacists. Attachments are allowed except for filing Medicaid claims. The claim form shall be accepted by all insurers and all agencies, departments, and divisions of the state.

Comprehensive Health Association Act

- Comprehensive health insurance is made available to citizens of Florida.
- It provides major medical coverage for persons unable to purchase insurance at 150% of the average standard risk rates.
- Annual deductibles of \$1,000, \$1,500, or \$2,000 are made available.
- Major medical coverage is provided up to a \$500,000 lifetime limit.
- All health insurance companies operating in Florida must participate in the cost of administering and operating the plan.

Optional Coverage for Mental and Nervous Disorders

- All group health insurance programs must make available as part of the application and at an additional premium coverage for mental and nervous disorders.
- The benefit levels are raised to \$1,000 and coverage is extended to partial hospitalization.
- Treatment by physicians and licensed psychologists, and any other mental health professionals as defined in the policy, is covered.

Nonprofit Health Care Services Plans

- Changed name from Hospital and Medical Service Plans.
- Allows for mutualization of nonprofit health care service plans.
- At least a majority of the directors shall be representatives of the general public and not of the health or insurance industries.

Health Maintenance Organizations

- Must have a minimum of \$100,000 working capital.
- For an additional premium, the HMO shall make available according to its standards and procedures physician care provided by a chiropractor, osteopath, or podiatrist.
- Any person damaged by a breach of a subscriber contract may bring a civil action against that person.

The Emergency Medical Services Law, which was up for "Sunset Review", was not acted upon. It is hoped that this will be considered in a special session later this year.

RESOLUTION 82-6 Certificate of Need Laws

Palm Beach County Medical Society

In view of the present activity of the Florida Medical Association, the Reference Committee moved an amendment be made to Resolution 82-6, by changing the "Resolved" to read:

"RESOLVED, That the Florida Medical Association continue to actively support legislation to repeal all Certificate of Need Laws."

The motion to adopt the amendment carried, and Resolution 82-6 was adopted as amended.

RESOLUTION 82-6 Certificate of Need Laws Palm Beach County Medical Society

RESOLVED, That the Florida Medical Association continue to actively support legislation to repeal all Certificate of Need laws.

RESOLUTION 82-10 Voluntary Health Planning Dade County Medical Association

The motion of the Reference Committee that Resolution 82-10 be amended by changing the words in the last "Resolved", "be prepared" to "Continue" carried.

Resolution 82-10 was adopted as amended.



FMA's new President, Robert E. Windom, M.D. (first row, second from left) obviously feels quite at home with members of his Sarasota County delegation. First row: Douglas R. Murphy, M.D.; Dr. Windom; Karl R. Roils, M.D.; and John N. Carlson, M.D. Second row: Martin F. Mihm, M.D.; Franklin H. Pfeifferberger, M.D.; Kenneth C. Kiehl, M.D.; and Richard C. Rehmeier, M.D.

RESOLUTION 82-10 Voluntary Health Planning Dade County Medical Association

RESOLVED, That the Florida Medical Association continue to oppose any legislative intent to provide state funding for local health planning programs, regardless of their name; and be it further

RESOLVED, That the Florida Medical Association endorse the AMA statement on voluntary health planning including the report of its Council on Medical Services on initiating voluntary locally-based health planning; and be it further

RESOLVED, That the Florida Medical Association and its component medical societies continue to develop and offer a rational alternative in the form of voluntary health planning to be implemented in the absence of federally mandated health planning programs.

RESOLUTION 82-20 Federally Funded Medical Student Loans Arthur L. Eberly, M.D., Delegate

The Reference Committee moved that in the title of Resolution 82-20, the word "Government" replace the word "Federally" and that the "Resolved" should be changed to read:

RESOLVED, That the Florida Medical Association request its legislative representatives to seek restoration of government funds for necessary student loans for medical students, and that repayment be enforced."

A motion made on the floor to change the word "government," in both cases, to "non-federal" failed to carry.

The motion of the Reference Committee that Resolution 82-20 be amended carried.

Resolution 82-20 was adopted as amended.

RESOLUTION 82-20 Government Funded Medical Student Loans Arthur L. Eberly, M.D., Delegate

RESOLVED, That the Florida Medical Association request its legislative representatives to seek restoration of government funds for necessary student loans for medical students, and that repayment be enforced.

The Chairman expressed deep appreciation on behalf of the Committee to Mrs. Helen Bradford who performed so efficiently as recorder for the Committee. The Committee also wished to express special thanks to Dr. Joseph Von Thron, the AMA Delegate who served as an advisor. Dr. Ackerman expressed his thanks to the members of his committee for their outstanding service.

The motion of the Reference Committee that the Report of Reference Committee No. IV be adopted as a whole, as amended carried.

Dr. Perry called the Chairman and members of Reference Committee V — Medical Economics, to present their report.

Report of Reference Committee No. V

Medical Economics

Dr. Franklin H. Pfeiffenberger, Chairman, and his committee came forward to present the report of Reference Committee No. V — Medical Economics.

Report E of the Board of Governors and Supplement

During the Committee's deliberations, extensive discussion took place regarding Recommendation No. E-1 of Report E of the Board of Governors and especially the section on telephone code numbers in the 1982 Florida Relative Value Studies.

A motion made from the floor to delete the lines of Recommendation No. E-1 beginning with "(1982 Florida Relative Value Studies Code Numbers)" up to the section on "Discounts" carried.

Council on Health Care Financing - The Reference Committee moved that a paragraph be added under the last item within the section entitled, "1982 Florida Relative Value Studies" to read:

"Special consideration will be given to the concerns of the radiologists when an update to the 1982 *Florida Relative Value Studies* is printed."

This amendment was adopted.

In all, Report E of the Board of Governors, including the paragraph in the supplement, along with the amendment to delete the section in Recommendation No. E-1, was adopted as amended.

Report E of the Board of Governors Sanford A. Mullen, M.D., Chairman

RECOMMENDATION NO. E-1

Board Actions of Major Importance

House of Delegates Referrals

RESOLUTION 81-3

*Physician Charges for Laboratory Services
and*

RECOMMENDATION NO. E-1
of the Board of Governors, 1981 House of Delegates

This resolution introduced by the Collier County Medical Society was not adopted but referred to the Board of Governors. The Resolved of this resolution would provide:

RESOLVED, That FMA allow the practicing physician to charge the prevailing fee as the medical reference facility would when billing the patient directly; and be it further

RESOLVED, That the FMA through its representation in the AMA urge designation of this practice as medically ethical and; be it further

RESOLVED, That the FMA petition the legislature to repeal or modify discriminating Florida Statute 483.245(1); and be it further

RESOLVED, That should legislative repeal fail, judicial action should be pursued; and be it further

RESOLVED, That the Florida Medical Association initiate judicial action against the implementation of the Department of Health and Human Services rule under Medicare Part B restricting reimbursement for laboratory services to physician's cost, charged by the reference or independent laboratory; and be it further

RESOLVED, That the FMA establish an escrow account by a mandatory assessment of the membership, the amount to be determined by the executive board after conferring with council for the purpose of funding legal expenses in this matter.

The House also referred Recommendation No. E-1 of the Board regarding physicians charges for laboratory services. This recommendation would provide:

- THAT IT IS PREFERABLE THAT THE LABORATORY, NOT THE ATTENDING PHYSICIAN, BILL AND COLLECT FROM THE PATIENT OR THIRD PARTY PAYER FOR LABORATORY SERVICES. WHERE CIRCUMSTANCES MAKE THIS IMPRACTICAL OR WHERE INCREASED COSTS TO THE PATIENT WOULD RESULT, THE BILL SUBMITTED BY THE ATTENDING PHYSICIAN TO HIS PATIENT OR THIRD PARTY PAYER SHOULD STATE THE NAME OF THE LABORATORY PERFORMING THE SERVICES FOR HIS PATIENT AND THE EXACT AMOUNT OF THE CHARGE PAID OR TO BE PAID BY THE PHYSICIAN TO THE LABORATORY. MEDICAL SOCIETIES ARE URGED TO USE ALL MEANS LEGALLY AVAILABLE TO THEM IN EFFECTUATING THE FOREGOING.
- THE ATTENDING PHYSICIAN IS ENTITLED TO FAIR COMPENSATION FOR THE PROFESSIONAL SERVICE HE RENDERS. HE IS NOT ENGAGED IN A COMMERCIAL ENTERPRISE, HOWEVER, AND ANY MARKUP, COMMISSION, OR PROFIT ON THE SERVICES RENDERED BY A LABORATORY IS EXPLOITATION OF THE PATIENT.
- IN BILLING PATIENTS FOR LABORATORY SERVICES WHICH ATTENDING PHYSICIANS PERFORM FOR THEIR OWN PATIENTS, THE BILL SHOULD PROVIDE INFORMATION TO SHOW WHERE SUCH SERVICES WERE PERFORMED, AS WELL AS AN ADEQUATE DESCRIPTION OF THE SERVICES PROVIDED AND THE SPECIFIC CHARGES MADE.

Pursuant to the actions of the House, the Board authorized the President to appoint a special ad hoc committee to review and make recommendations regarding this issue. The Board subsequently reviewed the Committee's report and approved a proposed policy statement to the House of Delegates.

RECOMMENDATION NO. E-1

THAT THE HOUSE OF DELEGATES ADOPT THE FOLLOWING POLICY WITH REGARD TO PHYSICIAN CHARGES FOR LABORATORY SERVICES:



Reference Committee V worked in the area of Medical Economics. Left to right: Fred S. Carter, M.D.; Eugene G. Peek Jr., M.D.; Ms. Joanelle Fulton, Recorder; Franklin H. Pfeifferberger, M.D., Chairman; Barney E. McRae, M.D.; and Calvin W. Martin, M.D.

- **THAT PHYSICIANS BE PERMITTED TO CHARGE A FAIR AND REASONABLE FEE FOR THEIR PROFESSIONAL SERVICES AND THAT IT IS ONLY FEASIBLE TO CHARGE TO THE PATIENT THE REFERENCE LABORATORY FEES, HOWEVER, THE PHYSICIAN MAY CHARGE IN ADDITION TO THE ABOVE A REASONABLE CHARGE FOR ACQUISITION OF THE SAMPLE AND A REASONABLE HANDLING CHARGE, AND A REASONABLE CHARGE FOR THE ORDERING AND EVALUATION OF THE APPROPRIATE DIAGNOSTIC TESTS, THE ADJUSTMENT OF THERAPEUTIC MANAGEMENT AS INDICATED AND THE DISCUSSION OF FINDINGS AND/OR MEDICAL MANAGEMENT.**

DISCOUNTS

FURTHER, THAT THE HOUSE OF DELEGATES RE-AFFIRM AMA AND FMA'S PREVIOUS POSITION:

- **THAT IT REAFFIRM THE AMA AND FMA'S PREVIOUS POSITION THAT IT IS UNLAWFUL FOR ANY PERSON TO PAY OR RECEIVE ANY COMMISSION, BONUS, KICKBACK OR REBATE OR ENGAGE IN ANY SPLIT-FEE ARRANGEMENT IN ANY FORM WHATSOEVER WITH ANY PHYSICIAN, SURGEON, ORGANIZATION, AGENCY, OR PERSON, EITHER DIRECTLY OR INDIRECTLY FOR PATIENTS REFERRED TO A CLINIC LABORATORY LICENSED UNDER CHAPTER 483.245.**

Resolution 81-10 — Discriminatory Reimbursement by Medicare — This resolution, introduced by the Seminole County Medical Society, was not adopted but referred to the Board of Governors.

The Resolved of this resolution called for the FMA to petition the Florida legislature to bring about an end to the gross inequity between the fees paid urban and rural physicians for Medicare in the state of Florida.

The Board approved a recommendation that the appropriate agency to be approached in carrying out the intent of the resolution was the Health Care Financing Administration of the federal government through the Medicare carrier, Blue Cross/Blue Shield of Florida. A petition has been filed to correct any existing fee inequities as stated in this resolution.

FMA Councils and Committees

COUNCIL ON HEALTH CARE FINANCING

Medicine and Business Coalitions — The Board endorsed the concept of physicians initiating the formation of and participation at a policy-making level of local medicine and business coalitions.

Physician Representative in Chamber of Commerce — The Board concurred with the Council's recommendation that component county medical societies accept responsibility for actively joining members of the business community in local Chambers of Commerce.

Medicaid Overpayments — The Board requested the Florida Physicians Association to investigate efforts of the Office of Medicaid Fraud and Abuse to recover retroactively alleged overpayments for office visit charges to physicians and report its findings to the Board.

Low Energy Assistance Program — The Board requested that the FMA Judicial Council review the forms required by the Department of HRS for the low energy assistance program as to the legal and ethical liability of physicians in filling out these forms. The Board further requested that contact be made with the secretary of HRS and that he be requested to insure that the application for low energy assistance include all provisions of the federal law.

PMUR — The Board endorsed the continuation of county medical societies' participation in peer medical utilization review for Medicare and authorized negotiations for continuing the PMUR contract for Medicare with Blue Cross/Blue Shield based on a drastically reduced budget allocation due to federal cutbacks in funding, and further, that county medical societies be reimbursed for a three-member PMUR Committee and that when the

occasion occurs, one member of the local PMUR Committee will represent his county society on the state committee and be reimbursed for time and travel.

(This action of the Board was based on the recommendation of the Council as a result of a meeting held with county medical society presidents and local PMUR representatives who unanimously approved of the concept set forth in the Board's action.)

1982 Florida Relative Value Studies — The Board approved funds for publication of the revised Florida Relative Value Studies in 1982 with the first copy to be provided to FMA members at no charge as part of their dues.

- The Board rejected inclusion in the RVS of qualifying circumstances for anesthesia 99100 and 99135 from page 50 of Current Procedural Terminology, Fourth Edition (CPT-4).
- The Board approved retention in the 1982 RVS of modifiers 37, 38 and 39, for anesthesia, and approved modifier 22 or unusual services when the service(s) provided is greater than that usually required for this listed procedure.
- The Board directed that FMA take appropriate action to protect the 1982 Florida Relative Value Studies from unauthorized supplements that may be developed by specialty groups, third party carriers or governmental agencies.
- The Board requested the Committee on RVS to consider possible solutions to the problem of procedures being eliminated from the 1982 RVS that were included in the 1975 publication as a result of such procedures not being listed in the charge data, collected for use in updating the RVS, particularly as it relates to pediatric surgery. The Board requested that every effort be made to minimize as much as possible, the number of RNE's (Relativity Not Established) included in the 1982 RVS.

Workers' Compensation — The Board reluctantly approved acceptance of an increase in the Florida Workers' Compensation 1982 Medical Services Fee Schedule to the 66 2/3 percentile of actual charge data as adopted by the Workers' Compensation Three-Member Panel January 7, 1982. The Board also requested that the FMA President write to each member of the panel expressing the continued desire on the part of the Florida Medical Association to work with them in securing a more equitable fee reimbursement under the Florida Workers' Compensation 1983 Medical Fee Schedule.

The Board authorized a study to be undertaken to support the need for a fee differential under the Workers' Compensation Fee Schedule for Palm Beach, Broward, Dade, and Monroe Counties.

The Board expressed highest commendation to Dr. Jim Richards, Chairman, and other members of the FMA Workers' Compensation Committee for their long and diligent efforts to help bring about an equitable level of reimbursement for physicians who participate in the Workers' Compensation program.

A historic review of the FMA's activities relative to the Workers' Compensation program and the Medical Services Fee Schedule can be found in the February 1981 issue of the FMA Journal.

Health Care Competition — The Board reviewed a proposed policy statement on several proposals being considered at the federal level regarding future financing and delivery of health care.

HMO's — The Board adopted the status report on Health Maintenance Organizations prepared by the Committee on Alternative Delivery Systems as an FMA resource document (Enclosure #4).

Redwood Foundation — The Board authorized a study of the approach taken by the Redwood Health Foundation, Sonoma and Mendocino-Lake Counties in California, in providing care recipients with particular respect to potential application in Florida.

Enclosure #3 to Board of Governors Report E Council on Health Care Financing

Proposed Policy Statement on Health Care Competition

General Background

In order to consider the subject of "competition" in proper perspective, one must realize that much of the motivation behind public policy for health care and its financing has arisen from the humanitarian rather than economic concerns. The driving force behind the government's involvement in health care in this country has been to provide readily available high quality care for everyone.

During the late 1960's and 1970's, the government concluded that there exists too much expenditure and the only way to control it is through regulations designed to bring about "cost containment." However, regulations have not worked so health theorists and governmental health policymakers have developed a new approach toward reaching the goal of "cost containment"; this approach is termed "competition."

Three of the leading health "competition" theorists have been credited with developing the foundations on which competition health care policy for the government is being based. They are Alain Enthoven, Martin Feldstein and Clark Havighurst.

Enthoven, a Professor of Management at Stanford Business School, has developed a pro-competition national health insurance scheme that would augment consumer choice based on encouraging the growth of Health Maintenance Organizations (HMOs). In an article entitled, "Consumer Choice Health Plan" in the *New England Journal of Medicine*, March 30, 1978, he argues that incentives driving providers must be changed so that "... physicians would accept responsibility for providing comprehensive health-care services to defined populations largely for a prospective per capita payment, or some other form of payment that rewards economy in the use of health-care resources." Enthoven and others theorize that all physicians would organize into competing economic units similar to closed-panel HMOs.

Feldstein, a Professor of Economics at Harvard University, focuses on the tendency of Americans to overinsure against predictable health costs and blames the annual \$10.8 billion federal tax subsidy for private health insurance plans as a prime contributor to the problem.

Havighurst, a Professor of Law at Duke University, has directed his attention to enforcing the anti-trust laws against health professionals who combine forces to restrain competitors, stymie insurers of cost containment measures, or reprimand members of their own professional groups who advertise or otherwise provide information on prices to consumers.

RECOMMENDATION NO. E-2

**THAT THE HOUSE OF DELEGATES ADOPT THE
PROPOSED POLICY STATEMENT ON HEALTH CARE
COMPETITION (ENCLOSURE #3).**

The basic premise underlying the "competition" theories is the assumption that if individuals are given an opportunity to choose among health insurance plans with a potential cash rebate for choosing one plan with less benefits, the individual will have an incentive not to overinsure and will accept financial responsibility for certain first dollar health care costs. The individual having to pay part of the cost for his health care is expected to use health services with a greater amount of discretion, experience and wisdom.

Under the "competition" proposals, a greater concentration of purchasing power for medical services is shifted to the sponsors of insurance plans. Under such plans, the sponsors are expected to exercise their purchasing power to control their subscribers' choice of physicians and facilities through special arrangements with them. The availability of care to planned subscribers is governed by such arrangements with controls established to limit costs, thus creating a competitive advantage. These ends would be based and fostered through contracts with providers, closed-panel arrangements such as HMOs, negotiated fee schedules and a greater reliance on large group practices, the end result being a lower cost to the individual subscriber.

Opinions Being Considered by President Reagan's Cabinet Council on Human Resources

Richard S. Schweiker, Secretary of Health and Human Services, presented a report to President Reagan's Cabinet Council on Human Resources during the week of December 7, 1981, which highlighted recommendations on "competition" from the DHHS Competition Task Force. The recommendations came in the form of five basic options including both the private and public sectors. It should be pointed out that final action by the administration may combine some or part of these options.

Option 1: Contributions made by employers to employee health plans are excluded from the employee's individual taxable income. Employers pay no Social Security or unemployment tax on the contributions, so as a result, the tax structure encourages employees to favor more and more first dollar health insurance coverage as an alternative to higher wages. This leads to "overinsurance", which drives up health care costs for everyone. The Task Force recommends a limit on employers' deductible excessive health insurance premiums. The limit might be a maximum of \$150 per month per employee with family coverage and \$60 per month for individual coverage. This could be indexed to the medical care component of the Consumer Price Index (CPI). Firms that currently have health plan contributions above the limits would be allowed to continue deducting their full base year contribution, but future increases would not be deductible until the indexed premium rises above their contribution.

Option 2: Employers will be encouraged to offer a choice of cost-effective health plans, including HMOs and a plan with 20 percent co-insurance on most services, and to give employees an incentive to enroll in them. Encouragement to employers could come in the form of tax credits to those who offer a choice of health plans. The credits could equal some fraction of the employer's start-up costs in moving from a single-plan to a multiple-plan arrangement. To qualify for the credit, employers would have to offer a plan with at least 20 percent co-insurance on all services except certain preventive services. To assure that workers are protected against catastrophic illness, all plans will have to limit a family's exposure to out-of-pocket costs to no more than \$3,500 per year, indexed to the medical component of the CPI. Employers who offer a choice of plans would have

to make the same premium contribution to all of them. As an incentive to select cost-effective coverage, those employees who choose a plan that costs less than the employer's contribution would get a tax-free cash rebate. To reduce adverse selection against the comprehensive plans, the rebate would be limited to some percentage of the difference between the premium of the high option plan and the premium of the plan actually selected, up to a maximum of \$50 per month per family or \$20 per month per individual. The maximum rebate would be indexed to the medical component of the CPI.

Option 3: This option would combine Option 2 with increased excise tax on alcohol and cigarettes. A portion of the increased tax revenue would be set aside to offset the tax revenue loss from the tax credits in tax-free rebates in Option 2.

Option 4: Option 4 would combine improved incentives for Medicare beneficiaries with added coverage for catastrophic illness. Under Medicare Part A, most patient cost-sharing is imposed late in the spell of an illness, after the 60th day, when the patient can least afford it and when it is too late to influence physician and patient behavior. There is no limit on the out-of-pocket cost a patient can incur after the 60th day.

According to the Task Force, Medicare rules discourage beneficiaries from enrolling in HMOs, and conventional insurers cannot enroll beneficiaries except for "Medigap" coverage. One possibility is to combine 10 percent co-insurance on all hospital days after the first day with an indexed \$2,500 per year limit on beneficiary cost-sharing limits on the number of covered hospital days.

Option 5: Beneficiaries would be offered the opportunity to enroll in private health plans. The Federal Government would offer to pay 95 percent of the adjusted average per capita cost to those enrolled in a private plan. This would be optional, and a beneficiary could switch back to Medicare during an annual open enrollment period. Both HMOs and the conventional insurers would be eligible to participate in this "voucher" system. To qualify, a plan would have to offer benefits at least as comprehensive as Medicare Part A and B. However, plans could offer added benefits to attract enrollees.

Discussion

Today it is recognized throughout the world that Americans have access to and receive the best medical care in existence. Most public opinion polls indicate that Americans are generally satisfied with both the quality and quantity of medical services. After years of consumer expectation of unlimited access to health care, government promoting proliferation of both providers and facilities, and physician willingness to provide varied medical services, it is necessary to examine the health care delivery system in terms of cost, its efficiency, and in some cases, its necessity.

The growth of health expenditures reflect our country's success in research to control many diseases, the development of new medical technology, and expansion of the health care delivery system to reach all our people.

The policy of the Florida Medical Association has been and will continue to be the delivery of necessary health care to the individual based upon effective, efficient and scientific principles. However, refining the system is not the same as replacing it with a system based on untried economic theory.

Policymakers and the public in general must realize that any effort to change the current system that separates cost and access from quality of care will do irreparable harm. One need only to

examine countries like England and Sweden to see what happens when costs become the overriding consideration. In these countries, the least productive of the society—the elderly—are being denied care. For example, Great Britain has a list of 800,000 individuals awaiting elective surgery to replace arthritic hips, faulty heart valves, and other conditions. Finally, in these countries the people are constantly accusing the government of providing medical care that is less than the best quality because of budget limitations.

No health policy can work in this country, including "competition", until the basic causes of general inflation are brought under control. Just like the economy in general, the health care delivery system is being driven out of control by rampant inflation: wages, supplies, technology, goods and services all impact the health care delivery system.

The "competition" theories fail to adequately recognize that government is a major part of the problem for the rise in health care costs. For decades, American health policy has been based on the idea that resources are limitless. We watched government pump federal dollars into the building of hospitals, training professionals and implementing programs, such as Medicare and Medicaid. In 1965, the federal government spent \$5 billion on health; today, it spends \$75 billion - about 11 percent of the entire federal budget. It is predicted by the year 1985 that, if no change occurs, the federal government will spend 132 billion dollars which represents 30% of the total health expenditure.

It is difficult to criticize government's desire to assist the elderly and make care available to indigents. What government can do is learn from past mistakes and realize programs which eliminate or lower patient's individual cost for medical care increases the amount of care he or she demands. Medicaid and Medicare, partly because of the initial miscalculation of demand, and secondly, because of the difficulty in determining current and future utilization, have stimulated a situation whereby these programs do not pay an equal share of the costs. As a result the private paying patient, either through his own recognizance or private third-party insurers, must pay the difference. The "competition" proposals do not adequately address this subject. There continues to be a problem in determining what is adequate and appropriate care partly because programs proposed by politicians are many times based on preconceived need rather than actual need.

In addition, programs such as Medicare, Medicaid, and first dollar coverage have helped to create a basic change in Americans' attitudes toward their personal responsibilities for their individual and family health. Today, most Americans believe that good health is a "right", yet at the same time, neglect their personal responsibility to maintain good health. Emphasis is placed on intervention after the onset of a disease or after an accident, not on less costly preventive health care.

The "competition" proposals do not adequately address the problems resulting from America's lifestyle. Of the ten leading high cost causes of death, the first six are dietary related: cancer, coronary heart disease, strokes, diabetes, hypertension and obesity. Nearly 20 percent of the total estimated cost of direct medical care is directly related to excess alcohol and tobacco consumption. More than nine million alcoholics will cost the nation over \$44 billion in medical bills and other related expenses, and smoking-related illnesses account for approximately seven or eight percent of the total direct health care costs. Accidents and suicides are still the leading causes of death among persons ages 1-44. The cost to the health care system as a result of accidents is second only to cancer. Neither "competition" nor any other economic theory will work without a major change in the American self-destructive lifestyle.

"Competition" does not address the impact of an ever-increasing growth in both our general and elderly population and the demands that this growth will have on the health care delivery system and future health care costs. The impact of and

on the elderly population is dramatic. For example, how will the elderly population, many of whom clearly have difficulty in filling out insurance claims, be able to make appropriate "consumer choices" in their own best interest? How will "Competition" protect our elderly from overinsuring and underinsuring, and what impact will over or underinsuring have on the community as a whole?

Medical Economist John Virts, in appearing before the Florida Statewide Health Coordinating Council, made the following statement which clearly needs to be addressed by the "competition" economic theorists:

"Using the most recent study available, it appears that 10 percent of the population consumes 50 percent of all health care. The bulk of our health care costs are therefore generated by caring intensively for a relatively small part of our total population. Furthermore, this concentration of consumption is virtually identical for all income classes. While not conclusive, such data would seem to be sufficient to at least indicate that:

- "1. In controlling expenditures, we may be literally dealing with a 'who shall live, and who shall die' question;
- "2. Income level, while clearly a possible determinant in some situations, is not in general an important answer to the question of who consumes how much health care."

The on-going professional liability crisis faced by both physicians and hospitals is not addressed by most "competition" advocates. Only Congressman Gephardt includes a provision for mediation panels in his proposed legislation. In 1963, 5.4 percent of the physicians insured was sued annually at an average cost per claim of \$4,138 with 100 percent of the claims closed. In 1980, this has exceeded 20 percent or one in five physicians per year with the average cost per claim exceeding \$23,000. Preliminary figures for 1982 place this in excess of \$33,000 per claim. Since 1963, using data from the Florida Medical Association sponsored Professional Liability Income Program only, there have been 10,324 closed claims with losses exceeding \$143,500,000. There is no central data base at the national level to give us an overall understanding of the magnitude regarding the impact the professional liability crisis is having on the cost of medical care. However, an indicator can be found in the results of a 1975 survey of 5,000 pediatricians conducted by the American Pediatric Society which showed that 40 percent of laboratory and x-ray services were done because of "defensive medicine". Unless the "competition" advocates address this issue, the cost of medical care will continue to rise.

The Florida Medical Association believes that all legitimate systems of health care delivery should be allowed equal participation in a free market. Because of the number of variables between the "fee for service" method of delivery and health maintenance organizations, quantitative comparisons are extremely difficult. One point that must be considered is the right of every individual to have "free choice" of physicians or medical care plans. The freedom of the individual to select his preferred system of health care and free competition among physicians and alternative systems of medical care and prerequisites of ethical medical practice and optimal medical care.

The recent action on the part of the Department of Health and Human Services for the use of public funds to promote enrollment of Medicare eligibles in health maintenance organizations was an arbitrary promotion of one type of medical care delivery service over others. The government by this action has restricted rather than promoted true competition. If HMOs are to be a *true option* under "competition", then they must float on their own in the free marketplace. Competition and risk go together and HMOs cannot expect to be protected by the government in order

to lessen the risk; that is, if government is to accurately evaluate the competitive impact of HMOs.

The American public, including the medical profession, should not be asked to support or accept the "competition" theories without their first being field tested. There are initiatives intended to change radically the health care delivery system as it currently exists.

The Florida Medical Association is concerned that the public will be misled into believing that "competition" is a substitute for regulation. To the contrary, certain premises in some of the proposed legislation would generate regulations resulting in a "regulated competition." For example, government will decide if mandated minimum benefits need to be established to protect employees from the danger of underinsuring; government will decide on coverage for individuals who currently cannot get insurance because of high-risk employment or health status. The Department of Health and Human Services may be given the authority to pre-empt state laws by nationalizing standards of medical care, directing basic coverage to be provided by employers and carriers, and establishing open hospital staff privileges.

The Florida Medical Association would like to point out that 20 percent of the health dollar goes to physicians and 40 percent goes to hospitals. The remaining 40 percent goes to extended care facilities, nursing homes, home health care, prescription drugs, transportation, etc. "Competition" is once again concentrating primarily on physicians and hospitals and not addressing 40 percent of the industry where some of the most notorious scandals have occurred.

In "competition", it is implied that the "risk-taking" is limited to insurers and providers. We feel that this is not correct. For example, there is risk to the employee if his health insurance plan fails in the competitive marketplace. If such a situation occurs under "competition", who pays the noncovered bills of the employee who, when confronted with the "consumer choice" options, selects the "cheap choice" insurance plan and later develops a sudden and expensive illness? What happens to the premium of the "comprehensive full-coverage choice" when only employees with potential expensive illnesses select it? How do you prevent this adverse selection? How will "insurance risk" be spread? When are risks shared by all parties and what happens to quality considerations by providers when competition becomes intense? How will "competition" interact with the multitude of problems created by the recent "health planning" effort that took place under PL 93-641, such as the limitation of communities to four beds per thousand?

Conclusion

In conclusion, the Florida Medical Association would like to emphasize that because of potential damage that could be done by totally initiating the "competition" economic theories, they *must* be first field tested and not implemented in a hasty fashion. It is imperative that cost, access and quality of care be treated equally under a "competition" program. There must be minimal government involvement in financing and regulation and no preferential treatment given to HMOs over other modes of funding and delivery. Government must be willing to make major changes in the funding and regulatory approaches it currently supports. Patients must be guaranteed "free choice" of physicians or competing health insurance plans. Consideration must be given to the future demands of a growing population. The professional liability crisis must be considered and a definitive plan of action taken within the "competition" program. And unlike what happened at the time Medicare and Medicaid were implemented, the medical profession should be made an equal partner in formulating the future of America's health care delivery system.

Supplement to Board of Governors Report E

The following language should be included as a footnote at the end of the proposed policy statement with regard to physician charges for laboratory services:

"The Ad Hoc Committee on Physician Charges for Laboratory Services, after recommending to the Board of Governors the reaffirmation of the FMA/AMA position on commissions, bonuses, kickbacks, rebates and splitfee arrangements, noted that the business of discounting was not included in the recommendation. However, it was the Committee's belief that any discounts should be passed on to the patient."

Council on Health Care Financing and Supplemental Report

The report of the Council on Health Care Financing and the Supplemental Report was adopted.

Council on Health Care Financing Charles P. Hayes Jr, M.D., Chairman

Because of the tremendous interest in and concern with medical economic issues, this year's Council on Health Care Financing was expanded with the addition of five new committees. Although the major thrust was given to the development of business coalitions, matters pertaining to the Workers' Compensation Program, and the revision of the 1975 *Florida Relative Value Studies*, all committees under the Council were active. A summary of these activities is reported below:

Committee on Alternative Delivery Systems

The Committee on Alternative Delivery Systems, chaired by William J. Garoni Jr., M.D., has monitored the growth of HMO's in Florida for fiscal soundness in view of federal withdrawal of funds. The Committee requested that a strong effort be made to require HMO's to continue to provide a core of basic medical services in order to compete on an equal basis with other modes of health care delivery. In addition, this Committee has emphasized that HMO's should not be given preferential treatment at either the national or the state level if they are to be considered a true alternative delivery system.

In other actions, the Committee developed an informational paper on Health Maintenance Organizations which was forwarded to the Board of Governors for their approval and appropriate action.

Committee on Automated Data Systems

The Committee on Automated Data Systems, chaired by H. Phillip Hampton, M.D., worked closely with all committees of the Council in the development of support materials to be used in establishing business health coalitions.

The Committee reports that technology and development capabilities for the application of electronic data processing and telecommunications to the current problems in health care delivery and financing is now available for use by the medical profession through Solution Systems by agreement with Data Communications Corporation of Memphis, Tennessee. The Florida Medical Foundation will supervise further development and applications required for approval and endorsement of the Florida Medical Association to insure continuing software support.



Among FMA notables attending one of the social events held in conjunction with the Annual Meeting were Yank D. Coble, M.D., and Mrs. Coble (left); and Charles P. Hayes, M.D., and Mrs. Hayes, both of Jacksonville. Dr. Coble was Chairman of the Council on Scientific Activities, while Dr. Hayes occupied the Chair of the Council on Health Care Financing.

Committee on Business and Industry Relations

The Committee on Business and Industry Relations, chaired by William T. Branch, M.D., concluded that the medical profession can be better served at the local community level if the county medical societies actively participate in local Chambers of Commerce. They should also stimulate the formation of and participate at the policy-making level of local medicine and business coalitions. The Committee developed a policy statement reflecting this position that was approved by the Board of Governors in August 1981. County medical societies were encouraged to place a high priority on the development of coalitions.

The Committee reported that coalitions currently exist in South Florida and in Hillsborough, Pinellas and Duval counties.

Committee on Cost Effectiveness

The Committee on Cost Effectiveness, chaired by James F. Richards Jr., M.D., recommended that the Florida Voluntary Effort develop a comprehensive plan for its future activities. It was recommended that its main efforts be geared toward public relations that focus on educating the general public. This could be accomplished by making available brochures in hospitals and physician waiting rooms and a series of television tapes about healthful lifestyles that could be viewed in classrooms and on public television. Also, the Committee proposed that the Voluntary Effort develop an educational program for community leaders regarding health matters.

Committee on Government Programs

Under the leadership of Frank B. Hodnette, M.D., Chairman, the Committee on Government Programs once again requested that there be an increase in Medicaid funding to support needed changes in the physician's fee schedule and to seek the employment of a full-time Medical Director for Medicaid. Recent budget cuts at the national level and proposals being put forth by the Reagan administration caused the Committee to advise the membership that the future of Medicaid is unpredictable at this time.

The Committee recommended that the Florida Medical Association investigate efforts on the part of the Medicaid Program to retroactively collect alleged overpayments from some physicians. Particular concern arose when some FMA members reported

that they had received policy directives from the Medicaid Program contrary to those used by the Medicaid Office of Fraud and Abuse as a reason for the recovery actions. This situation was discussed with the Department of Health and Rehabilitative Services and appropriate corrective action was taken by the Medicaid Program Office.

The Committee discovered and reported to the Committee on Relative Value Studies that some of the descriptors found in the 1975 *Florida Relative Value Studies* were being used out of context by Medicaid. It was recommended to the Board of Governors that careful consideration be given to future requests for Relative Value Studies copyright waivers so that this important publication is not seriously altered and used in a manner for which it was not intended.

Complaints were investigated by the Committee on the use of misleading and inappropriate forms which had to be signed by physicians in order for patients to be eligible for the new Low Income Energy Assistance Program. The Committee determined that the forms did not comply with federal guidelines and shared this information with the Secretary of the Department of Health and Rehabilitative Services. The Secretary was most cooperative and corrective actions were taken to redesign the forms so that they are in conformity with federal guidelines.

The Committee recommended to the Council on Legislation that the Association seek repeal of legislation passed in the 1981 Session requiring physicians to report to the Board of Medical Examiners whether they did or did not accept Medicare assignments.

It was recommended by the Committee that an in-depth study of the concept and format of the California Redwood Health Foundation providing care to Medicaid recipients be conducted with attention to its potential application in Florida. The Committee plans to follow through on this recommendation during the next Association year.

Committee on Health Insurance

The Committee on Health Insurance, chaired by Clarence M. Gilbert, M.D., monitored changes and financing of the health care delivery system. The Committee developed an informational paper on "Health Care Competition" for Board approval which will be made available to the membership of the Florida Medical Association.

The Committee also reviewed the House of Delegates' Resolution 81-10 and found the problem prompting the resolution had been resolved by the Medicare carrier, Blue Cross/Blue Shield of Florida, Inc.

In other actions, the Committee has developed the groundwork upon which to build a better working relationship with the many health insurance carriers doing business in Florida.

The Committee expressed concern over the development of two standards of peer medical utilization in Florida resulting when GHI elected not to contract with the Florida Medical Foundation for peer review.

The Chairman of the Council on Health Care Financing and the Chairman of the Committee on Health Insurance along with other members of the special Subcommittee of the Board on Health Insurance Sunset monitored closely the actions of the legislature as it pertained to the sunset of Florida insurance statutes.

Also, the Committee monitored the activities of the Florida Hospital Cost Containment Board in order to protect the membership from any broadening of the Hospital Cost Containment Board's role to include affairs of hospital-based physicians.

Committee on Health Planning

The Committee on Health Planning, chaired by Paul J. Popovich, M.D., carefully monitored proposed federal budget cuts and bloc grants which could result in loss of funding for needed health and medical programs. The Committee advised that every

effort should be made to maintain appropriate funding for medical programs in order to assure patients that they will have access to quality medical care.

The Committee also made several recommendations regarding proposed legislation to the Council on Legislation:

1. To oppose any effort to include walk-in emergency centers under the hospital licensure law as such could eventually lead to regulation and inclusion of physician's private office.
2. To continue to oppose the Hospital Cost Containment Board being authorized to regulate hospital rates or review hospital-based physicians who independently charge for their services.
3. To continue the Florida Medical Association's policy of attempting to repeal HSA legislation at the state level by use of the AMA Model Repeal Bill.

Committee on Peer Review Organizations

Under the leadership of Charles P. Hayes Jr., M.D., Chairman, the Committee on Peer Review Organizations has spent most of its time attempting to negotiate a new Medicare PMUR contract with the Medicare intermediary, Blue Cross/Blue Shield of Florida, Inc. Recent cuts in the Medicare administrative budget has provided the carrier with a yet to be determined amount of money that can be used for the purposes of contracting for PMUR services. The Committee plans to continue this negotiation until a satisfactory conclusion can be reached.

Committee on Relative Value Studies

The Committee on Relative Value Studies, chaired by Joel W. Mattison, M.D., has continued development of the 1982 *Florida Relative Value Studies* for dissemination to the membership in May 1982.

Presidents of specialty groups and representatives of the Council on Specialty Medicine were contacted and requested to provide input into the revision, culminating in a joint meeting of this Council and the Committee on Relative Value Studies.

Every effort has been made to assure the accuracy of the revised Relative Value Studies. It is the Committee's conclusion that the new RVS will be the most accurate and comprehensive relative value study that has ever been produced for use by medical doctors.

Committee on Workers' Compensation

James F. Richards Jr., M.D., Chairman of the Committee on Workers' Compensation, appeared before the Workers' Compensation Three-Member Panel on August 26 and December 10, 1981. At these hearings, the Panel was informed that the Florida Medical Association was requesting that physicians be reimbursed by the Workers' Compensation Program at their usual and customary fees. A second proposal was made that, if physicians could not be reimbursed their usual and customary fees, then the Workers' Compensation Program should reimburse them at the 75th percentile of actual charge with a differential for Palm Beach, Broward, Dade and Monroe counties.

On January 7, the Three-Member Panel met and recommended that physicians be reimbursed at the 66 2/3 percentile of charge data with the understanding that the Panel would work closely with the Florida Medical Association in reaching a more equitable reimbursement for physicians' services when the 1983 Workers' Compensation Fee Schedule is developed.

The Panel's recommendation to the 66 2/3 percentile was prompted by a report from the National Workers' Compensation Council which stated that Workers' Compensation rates in Florida would be significantly increased if the Program went to the 75th percentile. Because of the commitment on the part of the Three-Member Panel to work with the Florida Medical Association and

the fact that the difference between 66 2/3 percentile and 75th percentile for high frequency procedures was not that great, the Committee reluctantly recommended that the Board of Governors accept the proposed increase to the 66 2/3 percentile.

The Committee on Workers' Compensation is currently developing the supportive documentation and data which will be used in the Association's efforts to raise the 1983 Workers' Compensation Fee Schedule to a more equitable level.

After receiving numerous complaints regarding MEDATA of CALIFORNIA, the Committee conducted an investigation and determined that, for the most part, MEDATA was implementing the rules and regulations as set down by the Division of Workers' Compensation. The Committee continues to monitor this situation closely in hopes of resolving many of the problems currently being faced by physicians who provide services under the Florida Workers' Compensation Program.

Supplemental Report Council on Health Care Financing

The Council on Health Care Financing, after reviewing Resolution 81-12, had FMA staff meet with representatives of Blue Cross and Blue Shield of Florida, Inc., Florida Hospital Association and the Florida League of Hospitals to develop recommendations on how best to support the activities of the Florida Committee on the Cost of Medical Care (Voluntary Effort).

It was the unanimous conclusion of the participants in this November 3, 1981 meeting that Florida Committee on the Cost of Medical Care, because of its makeup, should not be involved in detailed programs such as hospital utilization review, etc. Instead, the Committee should direct its efforts toward public relations focusing specifically on the general public, legislature and school children. As a result of this conclusion, the public relations directors of the participating organizations were requested to outline some specific recommendations and provide an estimated cost figure for carrying out their recommendations. The following six recommendations were made:

1. Produce a new VE brochure for distribution in hospitals and physicians' waiting rooms.
2. Develop a series of taped vignettes to be used in schools aimed at children grades 1-7. In conjunction with taped vignettes would be a series of drawings denoting a good health habit to be filled in by color crayon. On the back of each drawing would be a health message concerning children to be taken home to parents.
3. Produce a "health inventory" program for commercial television stations in the form of a health quiz.
4. Give the members of the Florida Legislature a health quiz.
5. Produce radio public service announcements such as the FMA did with Dr. Shula.
6. Produce a card with basic Medicare information and the Blue Cross and Blue Shield of Florida's toll free number for Medicare patients to be made available in the waiting rooms of hospitals and physicians' offices.

The estimated cost of the program is \$30,000 which could be divided between the member organizations. The six recommendations have been submitted to the Florida Committee on the Cost of Medical Care for consideration at their next meeting.

The Council on Health Care Financing approved the six recommendations and presented them to the FMA Board of Governors. The Board of Governors accepted the recommendations as an information item. No further action can be taken on this matter until a meeting is held of the Florida Committee on the Cost of Medical Care (Voluntary Effort) at which time they would need to approve the recommendations and make a request for assistance in funding of these activities.

Florida Health Data Corporation

The report of the Florida Health Data Corporation was adopted.

Florida Health Data Corporation

James L. Borland Jr, M.D.
Immediate Past President

The Board of Directors of the Florida Health Data Corporation, having realized that not enough subscribing hospitals had joined the system to meet the financial obligations, entered into an agreement with McAuto. As a result of this agreement, McAuto continues to pay FHDC for each hospital debt that joins their system. Currently, twelve FHDC users have signed FHDC/McAuto contracts for a total of twenty-three hospitals that are included under the joint program.

FHDC has netted \$21,100.59 from McAuto which is being applied toward FHDC's obligation to PIMCO. It is anticipated that the total debt to PIMCO will be retired, while at the same time, continuing the FHDC in case there is a future need for its services.

**Report of
Florida Medical Foundation — PMUR**

The section of the Florida Medical Foundation's report concerning PMUR was adopted. [See Florida Medical Foundation Report, page 583].

**RESOLUTION 82-11
Containing the Cost of Health Care
Dade County Medical Association**

Resolution 82-11 - Containing the Cost of Health Care - was adopted.

**RESOLUTION 82-11
Containing the Cost of Health Care
Dade County Medical Association**

RESOLVED, That the Florida Medical Association suggests that its member physicians:

- Strive to become more keenly aware of the charges for hospital rooms, tests, and other medical services routinely ordered by the physician;
- Reduce cost and waste by requesting services based upon the availability of quality clinical information and realistic projections;
- Utilize outpatient testing whenever possible;
- Demonstrate cost-saving practices to third party payors to stimulate expansion of their policies to cover service provided through outpatient care;
- To obtain educational information from specialty sources as a means of keeping abreast of the most cost-effective ways of utilizing diagnostic tests and services.

**RESOLUTION 82-13
Prescription Requirements
Panhandle Medical Society**

The Reference Committee moved to amend the "Resolved" portion of the Resolution to read as follows:

"RESOLVED, That the Florida Medical Association take whatever steps are practical to have the Florida Department of Health and Rehabilitative Services rescind the onerous and distasteful requirement imposed upon physicians to add to prescriptions for non-steroid anti-inflammatory drugs the words 'medically necessary'."

The motion carried and Resolution 82-13 was adopted as amended.

**RESOLUTION 82-13
Prescription Requirements
Panhandle Medical Society**

RESOLVED, That the Florida Medical Association take whatever steps are practical to have the Florida Department of Health and Rehabilitative Services rescind the onerous and distasteful requirement imposed upon physicians to add to prescriptions for non-steroid anti-inflammatory drugs the words "medically necessary."

**RESOLUTION 82-15
Statewide Medical Peer Review
Sarasota County Medical Society**

**RESOLUTION 82-18
Professional Standards Review Organizations
Manatee County Medical Society**

The Reference Committee heard lengthy commentary regarding Resolutions 82-15 and 82-18. Considering these resolutions pertained to related subjects, the Committee offered a substitute resolution. Motions were made from the floor to amend the substitute resolution.

Substitute Resolution 82-15 - Statewide Medical Peer Review - was adopted as amended.

**SUBSTITUTE RESOLUTION 82-15
Statewide Medical Peer Review**

RESOLVED, That the Florida Medical Association continue to take a leadership role in promoting effective means of physician assessment of the quality of medical care regardless of the future fate of PSROs; and be it further

RESOLVED, That physicians continue to maintain control and direction over peer review and that peer review be done only by physician-sponsored organizations regardless of the funding source for such review; and be it further

RESOLVED, That physicians, acting through their county medical societies, continue to provide for the protection of the confidentiality of existing data accumulated for PSROs regardless of the future fate of PSROs; and be it further

RESOLVED, That the Florida Medical Association reaffirm current policy to continue physician-directed efforts to ensure that care provided to patients is of high quality, appropriate duration and is rendered in an appropriate setting at a reasonable cost, and to encourage the elimination of all government-directed peer review programs including PSROs, and be it further

RESOLVED, That the Florida Medical Association continue its efforts to establish a physician-directed statewide peer review organization.

Dr. Joseph C. Von Thron spoke briefly to the House about his recent appointment as Chairman of the Federal Professional Standards Review Council and stated that his position on PSRO's has not changed.

RESOLUTION 82-21

Relative Value Studies

David S. Hubbell, M.D., Delegate

Upon recommendation of the Reference Committee, Resolution 82-21 - Relative Value Studies - was not adopted.

The Reference Committee expressed its gratitude to those who appeared before the Committee.

Dr. Pfeifferberger expressed his appreciation to his Committee which he said was a most efficient and informed one, and expressed the Committee's appreciation to Charles P. Hayes Jr., M.D.; Charles K. Donegan, M.D.; and James F. Richards Jr., M.D. for their valuable input. The Committee also extended its appreciation for the informed assistance of Philip H. Gilbert, FMA Staff, and the efficient secretarial help of Mrs. Joanelle Fulton.

The motion of the Reference Committee that the Report of Reference Committee V be adopted as a whole as amended carried.

Elections

President - Elect

The Vice Speaker opened the floor for nominations for the office of President-Elect.

Dr. Orvin Jenkins, Past-President of Alachua County Medical Society, placed in nomination the name of Dr. J. Lee Dockery of Gainesville.

Dr. Jenkins' nomination was seconded by Dr. Guy T. Selander of Duval County; Dr. Robert E. Boyett of Dade County; Dr. Charles J. Kahn of Escambia; Dr. Robert N. Webster of Capital Medical Society; and Dr. Calvin W. Martin of DeSoto-Hardee-Glades who suggested that a unanimous ballot be cast.

A motion was made to close the nomination and unanimously elect Dr. Dockery and was carried.

Vice President

The floor was opened for nominations for the office of Vice President. Dr. T. Byron Thames of Orlando nominated Dr. James F. Richards of Orlando. There being no other nominations, Dr. Richards was elected by acclamation.

Speaker of the House

Vice Speaker of the House

Secretary

AMA Delegate Seat #2

AMA Alternate Seat #2

AMA Delegate Seat #3

AMA Alternate Seat #3

AMA Delegate Seat #5

AMA Alternate Seat #5

The Speaker entertained a motion to elect by acclamation candidates for Speaker of the House, Vice Speaker of the House, Secretary, AMA Delegate Seats #2, #3, and #5, and AMA Alternate Seats #2, #3, and #5, all of whom are incumbents and unopposed. The motion carried unanimously and the following candidates were elected:

Speaker of the House — James B. Perry, M.D.

Vice Speaker of the House — Franklin B. McKechnie, M.D.

Secretary — Luis M. Perez, M.D.



It was a happy Sunday morning for these FMA members who addressed the House of Delegates briefly after they were elected to offices in the Association. Left to right: President-Elect J. Lee Dockery, M.D., Gainesville; Vice President James F. Richards Jr., M.D., Orlando; and Treasurer Yank D. Coble Jr., M.D., Jacksonville.

AMA Seat #2 - Delegate - Samuel M. Day, M.D.
 AMA Seat #2 - Alternate - Luis M. Perez, M.D.
 AMA Seat #3 - Delegate - Charles K. Donegan, M.D.
 AMA Seat #3 - Alternate - Frank C. Coleman, M.D.
 AMA Seat #5 - Delegate - Richard G. Connor, M.D.
 AMA Seat #5 - Alternate - Vernon B. Astler, M.D.

The new terms for Delegates and Alternates are for two years (January 1, 1983, to December 31, 1984).

Treasurer

The floor was opened for nominations for the office of Treasurer. Dr. Robert Boyett of Dade County nominated Dr. Joseph T. Ostroski of Miami. The nomination was seconded by: Dr. Ernest G. Sayfie of Broward County; Dr. Edward D. Stoner of Orange; Dr. Robert P. Johnson of Capital Medical Society; Dr. William H. Meyer of St. Lucie-Okeechobee; and Dr. R. M. Carrera of Palm Beach County.

Dr. W. P. Booras of Duval County nominated Dr. Yank D. Coble, Jr. of Jacksonville, for Treasurer. The nomination was seconded by Dr. Calvin W. Martin of DeSoto-Hardee-Glades, Dr. Clarence M. Gilbert of Orange County, Dr. Charles J. Kahn of Escambia, Dr. Dick L. Van Eldik of Palm Beach County, Dr. Morris J. Levine of Pinellas, Dr. Franklin H. Pfeifferberger of Sarasota, Dr. Frank Agee of Alachua, Dr. Jerry D. Moore of Broward; Dr. R. G. Lacsamana of Volusia; and Dr. Thomas P. McKell of Hillsborough.

The ballots were counted and the Speaker announced that Dr. Yank D. Coble, Jr. had been elected Treasurer.

AMA Delegate - Seat #8

The Speaker opened the nominations for the new AMA Delegate Seat #8 for a term that began January 1, 1982, and will end December 31, 1983.

Dr. Vincent P. Corso of Miami was nominated for AMA Delegate Seat No. 8 by Dr. Norman M. Kenyon of Miami. This nomination was seconded by Dr. James A. Winslow, Jr. of Hillsborough and Dr. Charles A. Dunn of Dade County.

Dr. Clarence M. Gilbert of Orange County nominated Dr. Louis C. Murray for AMA Delegate Seat No. 8. The nomination was seconded by Dr. Dick L. Van Eldik of Palm Beach County, Dr. Irving M. Essrig of Hillsborough, Dr. Donald G. Nikolaus of Pinellas, Dr. William B. Deal of Alachua, Dr. Kenneth C. Kiehl of Sarasota and Dr. David C. Lane of Broward County.

The votes were counted and the Speaker announced that Dr. Louis C. Murray had been elected to AMA Delegate Seat No. 8.



As tellers counted votes cast in the contested race for Treasurer, Pensacola psychiatrist Philip B. Phillips, M.D. injected some levity into the proceedings. The House erupted in guffaw as Dr. Phillips presented a mytical slate of officers proposed by the Florida Psychiatric Society.

AMA Alternate - Seat #8

The floor was opened for nominations for AMA Alternate Seat No. 8. Dr. Guy T. Selander of Duval County placed in nomination the name of Dr. Sanford A. Mullen of Jacksonville.

Dr. Arthur L. Eberly of Broward, Dr. Victor H. Knight, Jr., of Hillsborough, Dr. V. A. Marks of Palm Beach County, Dr. John N. Carlson of Sarasota and Dr. Daniel L. Seckinger of Dade seconded the nomination.

Nominations were closed and Dr. Sanford A. Mullen was elected to serve in AMA Alternate Seat No. 8 by acclamation.

Judicial Council

The Speaker referred the House to the Report of the Board of Governors in which the Board had nominated Dr. Joseph H. Davis for re-election from Medical District D for a five-year term expiring in 1987.

The nomination was adopted and Dr. Joseph H. Davis was elected.

Committee on Membership and Discipline

The Speaker referred the House to the nominations for election to the Committee on Membership and Discipline as submitted by the Board of Governors in its report and asked for additional nominations from the floor. There being no nominations from the floor, it was moved and seconded that the

nominees as proposed by the Board of Governors be elected to the Committee on Membership and Discipline. The motion carried.

District 1	Lealis L. Hale Jr, M.D. (86)
District 2	James M. Dell Jr, M.D. (86)
District 3	Samuel J. Alford Jr, M.D. (86)
District 4	H. Frank Farmer Jr, M.D. (86)
District 5	Ross G. Olson, M.D. (86)
District 6	James T. Fleming, M.D. (86)
District 7	J. Robert Qualey, M.D. (86)
District 8	Thomas R. Busard, M.D. (86)
District 9	Francis S. Pooser, M.D. (86)
District 10	Fred S. Carter, M.D. (86)
District 11	Luis R. Guerrero, M.D. (86)
District 12	Peter A. Tomasello, M.D. (86)
District 13	Sheldon Zane, M.D. (86)
District 14	Chester Cassel, M.D. (86)
District 15	Norman L. Gottlieb, M.D. (86)

Dr. Windom recognized Dr. J. Russell Forlaw for his dedicated work as Treasurer. Dr. Forlaw did not seek re-election.

The following nominations for appointment to the Board of governors was announced by the President:

Gerold L. Schiebler, M.D. (A-86)
 Joseph T. Ostroski, M.D. (AL-83)
 Charles K. Donegan, M.D. (AMA Del.-83)
 Vernon B. Astler, M.D. (FPIR-83)
 Eugene G. Peek, Jr, M.D. (HRS-83)
 Robert N. Webster, M.D. (SBME-83)
 Mr. Scott Featherman (Student-83)

Charles K. Donegan, M.D., was designated the Optional Member of the FMA Executive Committee, and Vernon B. Astler, M.D., was appointed Public Relations Officer. The Florida Medical Foundation Board of Directors will include: Eugene G. Peek, Jr, M.D.; T. Byron Thames, M.D.; Norman M. Kenyon, M.D.; J. Lee Dockery, M.D.; and Yank D. Coble, Jr, M.D.

W. Harold Parham, D.H.A., Executive Vice President, introduced Mr. Donald C. Jones to the delegates and guests as the FMA's Executive Director and Chief Executive Officer.

The Speaker resumed the Chair and called upon Dr. O. William Davenport for the benediction.

The 1982 House of Delegates adjourned at 11:30 a.m.

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NOTES & NEWS

Three department chairmen appointed at South Florida

Appointments of chairmen for three major departments at the University of South Florida College of Medicine in Tampa have been announced by Andor Szentivanyi, M.D., Dean of the College and Director of the Medical Center.

Richard G. Connor, M.D., of Tampa, who has been an active leader in the Florida Medical Association and the American Medical Association for several years, is the new chief of the Department of Surgery. The other appointments include Martin L. Silbiger, M.D., of Tampa, Chairman of the Department of Radiology; and David T. Rowlands Jr., M.D., Chairman of Pathology.

Richard G. Connor, M.D. • Dr. Connor is a graduate of Duke University Medical School and has been a practicing thoracic and cardiovascular surgeon in Tampa since 1955. Since 1973, he has been a Clinical Professor of Surgery at the USF College of Medicine.

Dr. Connor has been active in many professional societies, including the American College of Surgeons, of which he has served as a Governor. He is a Past President of the Hillsborough County Medical Association and is a Florida Delegate to the American Medical Association. He also is a member of the AMA Council on Medical Education and the Liaison Committees for Graduate Medical Education, Specialty Boards and Medical Education.



Dr. Connor



Dr. Silbiger

Martin L. Silbiger, M.D. • Dr. Silbiger, the new Radiology Chairman, was educated at Oberlin College, the University of Pennsylvania and Western Reserve University. He received his radiology training at Johns Hopkins.

In Tampa, Dr. Silbiger has been Chief of Staff and Co-Director of the Department of Radiology at Tampa General Hospital, and President of the Florida

West Coast Radiology Society. Prior to his recent appointment, he has served as Clinical Associate Professor of Radiology at USF.

David T. Rowlands Jr., M.D. • Dr. Rowlands until recently was Professor of Medicine and Chairman of Pathology at the University of Pennsylvania. He has been a member of the faculty also at the University of Colorado, Rockefeller University and Duke University.

Certified in Anatomic Pathology, Clinical Pathology and Allergy and Immunology, Dr. Rowlands is noted for his research into antibody-antigen reactions.



Dr. Rowlands

New UF chief honored

David R. Challoner, M.D., who assumes duties this month as Vice President for Health Affairs at the University of Florida, has received one of the American Medical Association's highest honors.

Dr. Challoner received the Dr. William Beaumont Award of 1982 in recognition of his "outstanding contributions to medical research, teaching and clinical practice." The presentation was made in Chicago on June 13 during the annual session of the AMA House of Delegates.

The recipient is known in medical circles for his research and clinical expertise in endocrinology and metabolism. He was cited for his contributions to advancing biomedical knowledge through studies of insulin action in the body and the use of metabolic fuels by the heart.

Since 1975, Dr. Challoner has been Dean of the St. Louis University School of Medicine.

Dr. Rufus Broadway elected to AMA Board of Trustees

Rufus K. Broadway, M.D., of Miami, has been elected to a three-year term on the Board of Trustees of the American Medical Association.

Dr. Broadway was chosen in balloting conducted among members of the AMA House of Delegates at the AMA Annual Convention in Chicago in June.

The new AMA Trustee has a long record of service to organized medicine at local, state and national levels. He is a Past President of the Dade County Medical Association and has served as a member of the FMA Board of Governors.

Dr. Broadway has been a member of the Florida Medical Association House of Delegates for the past 20 years and has served as a member of the FMA delegation to AMA for more than a decade. He is a 1950 graduate of Harvard Medical School.



Dr. Broadway

Dr. Guy Selander installed as President of Florida Academy of Family Physicians

Guy T. Selander, M.D., of Jacksonville, has been installed as President of the Florida Academy of Family Physicians.

The installation of Dr. Selander, a Past President of the Duval County Medical Society and present Chairman of the Florida Medical Foundation Committee on Impaired Physicians, came at the Academy's Annual Meeting at Amelia Island in June. He succeeds Arthur L. Eberly Jr., M.D. of Pompano Beach, who will serve one year as Chairman of the Board of Directors.

Academy members selected Kendall M. Beckman Jr., M.D., of Melbourne as their President-Elect. Other new officers include Edwin W. Turner, M.D., of Homestead, Vice President; and Richard W. Dodd, M.D., of Daytona Beach, Secretary-Treasurer.

PLI UPDATE

Kentucky Supreme Court affirms countersuit award

A jury verdict awarding two physicians \$50,000 on a malicious prosecution claim was upheld by the Kentucky Supreme Court.

In 1975, a patient suffered a massive heart attack in his home. Upon examination at the hospital, it was discovered that he had a broken shoulder. The patient recovered and subsequently sued the hospital for allegedly breaking his shoulder. In 1976, the patient's attorney in the case filed an amended complaint, naming the radiologist who read the x-rays and the orthopedist who treated the shoulder as defendants. Because the attorney was counsel to another hospital, both the original and the amended complaints were signed by an associate, who did not read either complaint. Subsequently, the attorneys agreed to a voluntary dismissal of the charges against the two physicians.

The physicians then sued the attorneys, alleging malicious prosecution and abuse of process. They claimed that the malpractice action had caused them embarrassment, humiliation, mortification and mental anguish. After trial, a jury awarded each physician \$5,000 for physical and mental pain and suffering, \$5,000 for humiliation and loss of reputation, and \$15,000 in punitive damages.

Compensatory Damages • On appeal, the appellate court affirmed the compensatory damages against the attorney who prepared the complaints, but reversed as to the attorney who merely signed them. The appellate court reversed the awards of punitive damages. On further appeal, the State Supreme Court



Guy T. Selander, M.D., of Jacksonville (right) is installed as President of the Florida Academy of Family Physicians by Donald C. Nikolaus, M.D., of Dunedin, a member of the Board of Directors of the American Academy of Family Physicians.

upheld the punitive as well as the compensatory damages awards. The court examined the doctrine of malicious prosecution in some detail. The original complaint, although voluntarily dismissed, was terminated in the physicians' favor, the court ruled.

The attorney had assailed the physicians' reputations in filing his complaint alleging careless and negligent treatment, the court found. Under Kentucky law, this was sufficient to sustain an award for mental pain and suffering, the court said.

The basis for a malicious prosecution action is malice, not negligence. Thus, it is not sufficient to prove only that the attorneys did not conform to the standard of care of other prudent attorneys in filing the original malpractice claim. It is also necessary to prove that the suit was filed without probable cause. The breach of the duty of ordinary care becomes relevant with respect to establishing probable cause or the lack thereof, the court ruled.

Punitive Damages • In order to justify an award of punitive damages, the evidence must show malice, willfulness or wanton disregard of the rights of others. The trial court's instructions on malice were not prejudicial, and thus the punitive damages awarded were proper, the court held.

On the issue of process, the court distinguished this claim from malicious prosecution. The latter consists of maliciously causing legal process to issue; the former consists of using a legal process for some other purpose than it was intended. Furthermore, reputational injury is not sufficient to sustain an action for abuse of process. The court upheld the dismissal of this claim.

Finally, the court discussed the physicians' claims against the attorney who had signed the complaints without reading them. Although he probably exercised poor judgement in doing so, he was given a plausible reason why the other attorney did not wish to sign them, the court found. There was not sufficient evidence for the jury to find malice on his part, the court ruled.

The court sent the case back to the trial court, instructing it to enter a judgement against the first attorney, for both punitive and compensatory damages.

Contrasting with this decision is the Florida case of *Fee, Parker & Lloyd, P.A. v. Sullivan*, which involved a countersuit against a plaintiff's malpractice attorney brought by Dr. John B. Sullivan. Recognizing that a plaintiff in a malicious prosecution action faces the "difficult task of proving a negative, ie., the lack or probable cause", the Court in this case reversed a jury verdict in Dr. Sullivan's favor in spite of the fact that the plaintiff's attorney did virtually nothing to prepare his case.

Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel, and Anthony J. McNicholas III, J.D., Associate Legal Counsel, Professional Insurance Management Co. (PIMCO), Jacksonville, Florida.

DEAN'S MESSAGE

Assaults on our credibility and the need to interact

No man is an island, entire of itself; every man is a piece of the continent, a part of the main; if a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friends or of thine own were; any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee.

John Donne
Devotions XVII

John Donne's statement in the 17th Century is just as appropriate for physicians in the latter part of the 20th Century as we contemplate the assaults made on our credibility as professionals. The medical profession is viewed differently by various lay groups and not always positively. A few examples:

1. Health food advocates think we promote illness rather than health.
2. Government views us as dipping into the public till for our personal financial gains without accountability.
3. Environmentalists believe we are polluting our environment by using toxic drugs and nuclear-based diagnostic procedures.
4. Political radicals believe we chose to be physicians so we could solely reap financial rewards at the expense of the sick and downtrodden.
5. The underprivileged find it difficult to think of us as dedicated servants when they think we only work three and one-half days per week.
6. Finally, the press enjoys publicizing the individual malpractice suits but rarely the 90% plus that are never litigated because of that frivolity.

As Jerry Barondess of the American College of Physicians once said, "Medicine is *not* the sole master of its house." We live in an environment of constant groundswell of attacks which places us in a defensive posture.

It should be clear that what we are all about — that is, delivering the highest quality of medical care to the public at the lowest possible cost — has not been convincingly conveyed to the public.

The public doesn't read *The Journal of the Florida Medical Association*, *Journal of the American Medical Association*, *Annals of Internal Medicine*, *New England Journal of Medicine*, or even the *AM News* for that matter.

Television spots, radio spots, and news articles do precious little to tell our story.

We must increase our involvement in health policy. Development of health policy is unknown to our students. Our graduates and each of you need to know how to interact with policymakers — who are in the main, lay people.

We need to interact with other groups — the environmentalists, religious groups, and lawmakers.

But most importantly, we need to interact with our patients — listen to them — tell them our story — show them by your actions.

To prevent further erosion of public confidence in our profession, we must rededicate ourselves to a higher quality of patient-physician relationships.

"No man is an island..."

William B. Deal, M.D.
Dean, College of Medicine
University of Florida
Gainesville

The basic character and intellect of Sanford Mullen make him a natural leader for organized medicine. He is a superb physician with excellent overall perspective; a personable gentleman of the highest order; a progressive thinker with a pragmatic approach; an articulate speaker; a diligent worker; a fair-minded and altruistic individual with a healthy sense of humor; and a devoted loving husband and father. It is particularly revealing of the true quality of the man that while serving as president of the FMA he never lost his willingness to help potential leaders from his own county society.

Dr. Mullen, for your statesmanship and numerous contributions to organized medicine, I salute you!

Daniel B. Nunn, M.D.
Jacksonville

Reprinted from *Jacksonville Medicine*, July 1982.

WORTH REPEATING

A tribute to Sanford A. Mullen, M.D.

The Duval County Medical Society has ample cause to be proud of our own Sanford A. Mullen, M.D., president of the Florida Medical Association, 1981-1982. As a member of Dr. Mullen's FMA team, I was privileged to witness firsthand many of his activities dealing with the establishment and implementation of FMA policy. By virtue of this experience, I learned a great deal about the man himself, and I ended the year with a strong appreciation and admiration for Dr. Mullen's leadership capability and personal character. Consequently, I wish to offer the following commentary on Sanford A. Mullen, truly a man profound with a wide diversity of meaningful interests and talents.

From the outset, it was readily apparent that Sanford Mullen is a dedicated physician who shares a sincere concern for the entire medical profession and the public it serves. I am convinced that this concern together with a desire to improve health care in Florida provided the motivation for Sanford's quest of the FMA presidency. Quite appropriately, the theme of the Mullen presidency was, "Active Physician Involvement in Community Affairs." With his own record of outstanding community service, Sanford epitomized the theme and his remarks on this subject echoed throughout the year: *Being a doctor is not enough. We owe it to ourselves and others to get involved as much as possible in community activities, especially the political process since government ultimately affects the manner in which we practice.*

The national library of medicine and how to use it

It is the act of writing that gives order and structure to the thoughts and observations of a scientist. It is the published book or journal that gives permanence to this knowledge. And, it is the library that collects, organizes, and makes this literature available to all.

Dr. Martin Cummings, Director
National Library of Medicine

Unfounded criticism has come from a few individuals casting doubt on the wisdom of spending approximately \$45 million yearly to maintain the National Library of Medicine and its extramural programs. Much of this criticism results from not understanding the nature, scope, function and worth of this great national resource. An understanding of the importance of the library to the medical profession and others with scientific interest is needed.

In 1836, the year Texas became a republic and the year before Queen Victoria was crowned, the Army Surgeon General established a library for the medical officers of the U.S. military. An eminent physician, John Shaw Billings, in 1865 expanded the service to include other physicians and became the founding father of the National Library of Medicine. For 30 years he continued to direct the library, and in 1879 he published the first *Index Medicus*, a service which has continued down to today. Billings increased the size, scope and depth of the collection; he purchased for it, he exchanged for it, he sought donations and gifts for it. The library became his soul and he its servant.

The armed services sponsored the growing repository of books and nourished it for 120 years. Congress recognized its growing importance, and in 1956 legislation was passed officially designating it the National Library of Medicine.

Placed within the Public Health Service (Department of Health and Human Services) the library uses advanced technologies to store, retrieve, and disseminate biomedical information for the use of interested scientists, physicians, and medical workers. This is its goal and its hallmark.

In 1968, Congress established a new library component, the Lister Hill National Center for Biomedical Communications, to develop through research new medical communication technologies.

At present the National Library of Medicine (NLM) is the largest research library in a single scientific and professional field in the world. The interplay of basic sciences of chemistry, physics, zoology, botany, psychology, and medical instrumentation supports the broader interests of biomedical knowledge. Journals, books, pamphlets, reports, theses, microfilm, prints and photographs, and audiovisuals, over 2.5 million in over 70 languages, are processed and computerized. The library maintains one of the world's finest medical history collections, with books and papers dating from the 11th to the late 19th century.

Through a nationwide NLM network, the library is a research source for more than 4,000 universities, medical schools, hospitals, government agencies, and commercial organizations. It supports 11 regional medical libraries, each responsible for its geographic area and for coordinating NLM "on-line" search services. The regional libraries, like NLM, handle requests for health literature. In addition, there are 100 resource libraries working with NLM to better serve the biomedical community.

The purpose of a library is not only the accumulation of information but also the dissemination of this information to those persons who need and use it. This is the function of the National Library of Medicine.

How should the library be used? Go to the health science library in your community and talk to the librarian about the information you need. The librarian then will initiate the search for the necessary materials. Many questions can be answered in the local library. Much information can be found in ordinary texts and journals. Ordinarily, textbooks of medicine and surgery have not been placed on-line at the NLM. Readily available informational sources should be used before going to NLM information stores. Remember the legal ruling on photocopying, only one copy for study is permitted.

The Medical Literature Analysis and Retrieval Systems (MEDLARS) includes 4.5 million references to journal articles and books on health published in *Index Medicus*. A user may search via NLM computers to obtain pertinent information on a specific problem.

It is possible to search for references by using words in article titles and abstracts as well as by using

the 14,000 designated medical subject headings (MeSH) used by NLM in indexing and cataloging material.

The MEDLARS computerized on-line data bases are available for searching from terminals located in about 1,300 health science institutions in the United States. These institutions include hospitals, medical schools, government agencies, commercial organizations, and research facilities.

The help of an experienced librarian may be needed in retrieving this information, but it can be done quickly and more economically by MEDLARS than by any other system. Complicated searches are best left to librarian specialists.

Books or articles, even if they are not held in the collections of local or regional medical libraries, can be located by on-line computer search through individual institutional libraries.

There are nominal charges for a search, covering cost of computer connection and staff time. An extensive bibliography that would be too expensive to be received at the local library terminal can be printed at NLM and mailed the following day. Charges for such services are nominal.

Medical literature "on-line" (MEDLINE) contains approximately 600,000 references to biomedical journal articles published in the current and two preceding years; many abstracts are also included. Articles come from 3,000 journals published in the United States and 74 foreign countries. Selected monograph articles are also in MEDLINE. Dating from 1966, back files contain more than 2.5 million references. MEDLINE is updated monthly when new references are added to the data base.

Thanks to the foresight of Dr. Billings and his successors, and to Congress, the National Institutes of Health, and those thousands of dedicated physicians and scientists who have published scientific work, a wealth of information is available to you. It is your library, the best in the world. Use it and support it. No other discipline — law, education, industry, labor, religion, or agriculture — has such a resource.

Emmet F. Ferguson Jr., M.D.
Jacksonville

Reprinted with permission from the *Journal of Family Practice*, Vol. 14, No. 2, 1982.

**Let's not judge
disabled people by what
they can't do but by
what they can do.**

President's Committee on
Employment of the Handicapped
Washington, D.C. 20210



CORRESPONDENCE

On the well-elderly check-up

Editor's Note: John Deller, M.D., Palm Springs Academy of Medicine, Rancho Mirage, California, wrote an article for the Special Issue on the Process of Aging, (Vol. 69, No. 4). In the letter below, Mitchell Shapiro, M.D., addresses the use of Tonometry as an addition to "The Well-Elderly Check-up".

To the Editor: In an otherwise excellent review article labeled "The Well-Elderly Check-up", Dr. Deller in his examination of the eye has omitted Tonometry. The potential problem which can easily be diagnosed by the Schiotz Tonometer is of course, glaucoma. This is certainly a disease of the elderly beginning at the age of forty with approximately two percent of the population and increasing by approximately one percent per decade. The disease is so often not diagnosed until its phases when the therapeutic possibilities are much more limited and the visual acuity is irreversibly decreased.

*Mitchell Shapiro, M.D.
Altamonte Springs*



ETC.

Substance abuse program at Winter Park in August

The Florida School of Substance Abuse Studies, Inc., will conduct a program at Rollins College in Winter Park, August 8-11.

Curriculum tracks will focus on treatment, criminal justice, DWI and occupational programming. Faculty will include Harrison Trice, Ph.D., Professor, New York School of Industrial and Labor Relations, Cornell University, Ithaca, N.Y.; David J. Pittman, Ph.D., Chairman, Department of Sociology, Washington University, St. Louis, Mo.; Conway Hunter, M.D., Corporate Medical Director, Addictive Disease Division, Charter Medical Corp., Georgia; and James L. Malfetti, Ph.D., Professor of Education, Teachers College of Columbia University, New York.

Registration fees include \$100 for the complete program of \$50 for one day. Information may be obtained from Florida School of Substance Abuse Studies, Post Office Box 13428, Tallahassee, Florida 32308, telephone (904) 222-6314.

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Each one get one

The mandate of our new membership chairman, Jo Tignor, to Auxilians throughout Florida is "Each One Get One". Can you think of a better way to enlarge our organization? If each one of us could convince one other doctor's spouse (perhaps yours) to join Auxiliary, we would number nearly 12,000.

How can we possibly do this? There is only one way. A positive example of friendliness and productive involvement attracts new fellow workers. Encouragement from you physicians would be a tremendous help in this effort. It is to your advantage because Auxiliary exists to enhance and promote your programs and projects. We could function far more effectively in legislative activities, health education, medical and para-medical scholarship programs, and community service.

Happiness and Satisfaction • Increasing numbers is not an end in itself. Winning membership awards is gratifying, but seeing members benefit from the organization by accomplishing personal goals and utilizing their potential is the true reward. Helping one another learn to be happier is essential. Those of us who have been closely involved with Auxiliary for a period of time realize that true happiness and satisfaction come primarily from helping those who need us — our families and community. It is our aim to put ourselves in optimum condition, physically and emotionally, to strive toward the ultimate Auxiliary goal. That is to expand the role of the physician in promoting the best possible health care for the community, state, and nation. We need to be his third hand, because his left and right are completely occupied with the everyday responsibilities of quality medical practice.

Unlike many groups which distract one from the duties of home life, Auxiliary emphasizes programs fostering family stability for members and the community they serve. It is not a frivolous social club, but it does offer opportunity for physicians' spouses to associate with their peers. It is a positive reinforcement of their roles. There is a common understanding of the particular need for doctors' spouses to be adaptable, empathetic, resourceful, and supportive in

relationships with their mates and other family members. The privilege of being a physician's spouse carries with it responsibilities. Auxiliary recognizes that the medical community is judged partly by the image of the doctor's spouse. We strive continually to perfect that image with compassion and worthwhile community involvement.

By definition membership implies commitment. There are at least three types of commitment — short term, long term, and lifetime. Auxiliary encompasses all three. Ad hoc committee work is relatively short term, as are certain health projects such as worry seminars, blood donor drives, and screening programs. Standing committees, offices, and chairmanships require long term involvement and willingness to sacrifice time and expend effort for a more extended period. Actually, however, membership in Auxiliary should be considered a lifetime commitment because it is geared to all phases of the life cycle.

Auxiliary Meetings and Activities • New spouses are welcome and helped to adjust to the community. If they desire, they are put to work immediately on programs of their choosing. Spouses of student and resident physicians are encouraged to participate in Auxiliary activities, giving them an opportunity to prepare for the real world of medical marriage. Most Auxiliaries stagger meeting times so that spouses who are employed may benefit from and contribute to the group. Babysitting co-ops allow for participation by mothers of young children. Older members, wives of retired physicians, and doctor's widows play a vital part in the Auxiliary picture because of their dedication and expertise. Continued membership offers opportunities for growth, sometimes even leading to new or revitalized careers.

If you are looking for a very important gift for your spouse, what about a Membership in the Auxiliary? It will open new vistas and offer a lifetime of opportunity and potential purposeful involvement. It cannot be lost or stolen and is guaranteed to improve with age!

*Mrs. Fred P. (Anne) Swing
Past President, FMA-A
Charlotte Harbor*

Meetings

Accepted by the
FMA Committee on
Continuing Medical
Education for
Mandatory Credit

AUGUST

Fundamental and Clinical Aspects in Internal Medicine (A Review for the Boards in Internal Medicine) Aug. 1-14, Key Biscayne Hotel, Key Biscayne. For information: Dr. Jose Bocles, Dept. of Medicine, University of Miami, School of Medicine, P.O. Box 016960, Miami 33101.

Evoked Potentials, Aug. 3, Naples Community Hospital, Naples. For information: R.L. Duncan, M.D., 831 Fourth Ave. North, Naples 33940 (813) 261-5511.

Second Congress of Columbian Doctors in the U.S.A., Aug. 6-7, Hyatt Regency Hotel, Tampa. For information: Hugo A. Ramirez, M.D., Sam A. Nixon, M.D., (713) 792-4671.

Emergency Medical Update, Aug. 13, Jupiter Hilton, Jupiter. For information: Orton V. Carr III, M.D., Medical Center Hospital, 1210 S. Old Dixie Highway, Jupiter 33458.

Arrhythmias and Cardiac Ischemia: Diagnosis and Management, Aug. 13-15, Hilton Gateway, Orlando. For information: International Medical Education Corporation, Division of Postgraduate Education, 64 Inverness Drive E., Englewood, Colorado 80112.

American Heart Association ACLS Course, Aug. 16-18, Naval Regional Medical Center, Jacksonville. For information: Frank J. Kuczler Jr., M.D., Naval Regional Medical Center, NAS Jacksonville 32214, (904) 772-2227

Comprehensive Review Course for ECFMG, FLEX, VOE (In English) Aug. 16-Nov. 24 (runs the full three months), Four Ambassador Towers Condominium, Tower 3, Suite 1950, Miami. For information: Rafael Penelver, M.D., University

of Miami School of Medicine Office of International Medical Education, Miami 33101.

Bone Pain and Lytic Lesion of the Left Femur in a 75 Year Old Female, Aug. 20, Naples Community Hospital, Naples. For information: Mrs. Taylor, CME Depart. of the Naples Community Hospital, Naples 33941, (813) 262-3131.

SEPTEMBER

Technical Aids for the Disabled, Sept. 3-4, Hilton Hotel, Daytona Beach. For information: Convention Management Consultants, 5401 Kirkman Road, Suite 550, Orlando 32805, (305) 351-2592.

Basic Mechanisms and Clinical Applications of Slow-Channel Blockers, Sept. 7, Holy Cross Hospital, Fort Lauderdale. For information: Jon R. Fichtelman, M.D., P.O. Box 23460, Fort Lauderdale 33307.

Hypertensive Emergencies, Sept. 8, Naples Community Hospital, Naples. For information: Steven Preston, M.D., 275 Eighth Street South, Naples 33940, (813) 262-8585.

Common Knee Problems in the Professional Athlete, Sept. 8, Lakeland Yacht and Country Club, Lakeland. For information: Eugene L. Nagel, M.D., P.O. Box 927, Lakeland 33802.

Polk County Medical Association 1982 Dinner Meeting Programs, Sept. 8, Lakeland. For information: Eugene L. Nagel, M.D., P.O. Box 927, Lakeland 33802.

Tips, Tricks, Traps and Techniques, Recent Developments in Family Practice, Sept. 9-12, St. Augustine. For information: James R. Biggerstaff, M.D., 1406 Kingsley Avenue, Orange Park 32073.

Left Ventricular Dysfunction, Ventricular Ectopy and Sudden Cardiac Death, Sept. 21, Holy Cross Hospital, Fort Lauderdale. For information: Jon Fichtelman, M.D., Post Office Box 23460, Fort Lauderdale 33307.

Basic, Intermediate and Advanced Workshop in Clinical Hypnosis, Sept. 23-26, Holiday Inn Florida Center, Orlando. For information: Charles Mutter, M.D., Educational Research Foundation, (305) 547-2000.

OCTOBER

16th Family Practice Review, Oct. 4-8, Hotel Royal Plaza, Lake Buena Vista. For information: Lamar Crevasse, M.D., Box J-233, JHMH, Gainesville 32610.

Management of Burn Victims: Emergency, Acute and Rehabilitative Phases, Oct. 7-8, Miami. For information: Ms. Gloria Allington, (305) 547-6716.

8th Annual OB/GYN Review Course, Oct. 8-16, Royal Biscayne Hotel, Key Biscayne. For information: University of Miami School of Medicine (305) 547-6944.

OB/GYN Pathology Review Course, Oct. 10-12, University of Miami School of Medicine, Dept. of OB/GYN, P.O. Box 016960, Miami 33101, (305) 547-6944.

Pediatric Nephrology, Oct. 11, International Hospital, Miami. For information: Alfredo Cruet, M.D., and Marcella Schaible, (305) 547-6604.

Violent Crime: An Epidemic, October 13, Quality Inn, Cypress Gardens, Winter Haven. For information: Eugene L. Nagel, M.D., P.O. Box 927, Lakeland.

Brief and Emergency Psychotherapy: A Seminar, Oct. 14-15, Sarasota Hyatt House, Sarasota. For info.: Nancy Skotchdopole, ACSW, P.O. Box 2024, Leesburg, 32748, (904) 787-9178.

89th Annual Meeting of the Association of Military Surgeons of the U.S., Oct. 17-21, Convention Center, Sheraton Twin Towers Hotel, Orlando. For information: Captain Jay R. Shapiro, USPHS (305) 496-3515.

Annual Medical Aspects of Aging, Oct. 22-23, Gainesville Hilton, Gainesville. For information: Ms. Grace Wagner, Coordinator, University of Florida

CME, Box J-233, JHM Health Center, Gainesville 32610, (904) 392-3143 or 3183.

23rd Annual Workshop in Electrocardiology, Oct. 28-Nov. 1, Sheraton Sand Key Hotel, Clearwater Beach. For information: Henry J.L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705, (813) 894-0790.

Annual Meeting, American Pain Society, Oct. 29-31, Konover Hotel, Miami Beach. For information: Kenneth L. Casey, Neurology Service, VA Medical Center, Ann Arbor, Michigan 48105, (313) 769-7100, ext. 296.

Current Advances in Perinatology, Oct. 31-Nov. 6, St. Thomas, U.S. Virgin Islands. For information: University of Miami School of Medicine, Dept. of Pediatrics, P.O. Box 016960, Miami 33101, (305) 547-6411.

NOVEMBER

Pacemaker Electrocardiography and Dual Chamber Pulse Generators, Nov. 3-5, Wolfson Auditorium, Mount Sinai Medical Center of Greater Miami, Miami Beach. For information: Philips Samet, M.D., (305) 674-2311.

Clinical Management of Coronary Disease and Dual-Mode Exercise Testing, Nov. 5-7, Hilton Gateway, Orlando. For information: Stephen E. Mattingly, International Medical Education Corporation, 64 Inverness Drive E. Englewood, Colorado 80112.

Glimpses Forward — Clinical Applications of New Diagnostic Imaging and Interventional Techniques, Nov. 11-13, Wolfson Auditorium, Mount Sinai Medical Center, Miami Beach. For info.: Manuel Viamonte Jr., M.D., 4300 Alton Road, Miami Beach 33140, (305) 674-2311.
32nd Annual Postgraduate Seminar — Glimpses Forward

Maxillofacial Pain Symposium, Nov. 20 and 21, Gainesville Hilton, Gainesville. For information: Marvin M. Slott, M.D., 6510 N.W. 9th Blvd., Suite #4, Gainesville 32605, (904) 377-2016.

Clinical Allergy and Immunology for the Practicing Physician, Dec. 2-4, Dutch Inn Resort Hotel, Lake Buena Vista. For information: Richard F. Lockey, M.D., University of South Florida, College of Medicine, Division of Allergy, (813) 971-4500, ext. 596.

Neuro-Ophthalmology, Dec. 2-4, Miami. For information: University of Miami School of Medicine, Dept. of Ophthalmology (D880), P.O. Box 016960, Miami 33101.

ECG Interpretation and Arrhythmia Management, Dec. 3-5, Bahia Mar Hotel, Fort Lauderdale. For information: International Medical Education Corp., Division of Postgraduate Education, 64 Inverness Drive E., Englewood, Colorado 80112.

Advances in Technology for the Management of Musculoskeletal Disability, Dec. 6-8, Miami. For information: Univ. of Miami School of Medicine, Dept. of Orthopedics (D27), P.O. Box 016960, Miami 33101.

Ultrasound As Used In Modern Obstetrics and Gynecology, Dec. 8-12, Miami Beach. For information: University of Miami School of Medicine, Dept. of OB/GYN, P.O. Box 016960, Miami 33101.

Brain Site Specificity of Neurotropic Drugs, Dec. 9, Dept. of Health and Rehabilitative Services, Building 1, Room 304, 1323 Winewood Blvd., Tallahassee. For information: Charlotte Maguire, Building 1, Room 304, 1323 Winewood Boulevard, Tallahassee.

Interamerican Medical Symposium — 3rd Annual Course, Dec. 12-17, Miami Beach. For information: Dept. of Medicine (R760), P.O. Box 016960, Miami 33101.

JANUARY 1983

28th Annual Cardiovascular Seminar, Jan. 7-8, Dolphin Beach Resort, St. Petersburg Beach. For information: Mr. E. Jerry Eatman, P.O. Box 7188, St. Petersburg 33734.

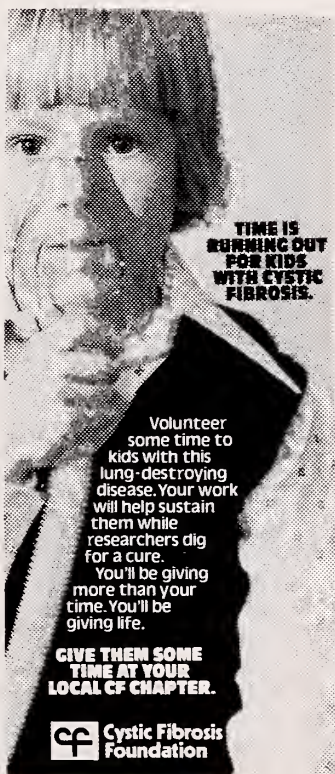
6th Annual Review in Oral Pathology, Jan. 10-14, University of Miami, Miami. For information: University of Miami CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

Grand Prix Road Racing — Medical Aspects, Jan. 12, Peace River Country Club, Bartow. For information: Mrs. Elsie Trask, Exec. Dir., Polk County Medical Society, (813) 682-0543.

Coexistent Pulmonary and Cardiac Disease, Jan. 12, Mount Sinai Medical Center, Miami. For information: Marvin L. Meitus, M.D. and Adam Wanner, M.D., 4300 Alton Road, Miami Beach 33140, (305) 674-2311.

8th Annual Review and Recent Practical Advances in Pathology, Jan. 17-21, University of Miami, Miami Beach. For information: Univ. of Miami School of Medicine, Dept. of Pathology, P.O. Box 016960, Miami 33101, (305) 325-6437.


Acute Spinal Cord Injury — Comprehensive Management, Jan. 19-23, Univ. of Miami, Miami. For information, CME, University of Miami School of Medicine, P.O. Box 016960, Miami 33101, (305) 547-6716.



TIME IS RUNNING OUT FOR KIDS WITH CYSTIC FIBROSIS.

Volunteer some time to kids with this lung-destroying disease. Your work will help sustain them while researchers dig for a cure. You'll be giving more than your time. You'll be giving life.

GIVE THEM SOME TIME AT YOUR LOCAL CF CHAPTER.

 **Cystic Fibrosis Foundation**

SAVE IT AT WORK

Don't blow your company's profits and your pay raises by wasting energy at the office or plant.

When you waste energy at work, you not only hurt your state and your country, you also hurt your employer and yourself. Because you're literally burning up money that could be used for a lot of other worthwhile purposes — including pay raises.

Here are six ways you can save a lot of money and energy at work.

1. Turn off the lights when no one is working and you'll brighten Florida's energy future.
2. Utilize the most energy efficient equipment in offices and factories. Equipment drains energy and eats up profits.
3. Keep temperatures no lower than 78° in summer; no higher than 65° in winter. And dress accordingly.
4. Have a professional energy audit to discover the dozens of different ways your company can become more energy efficient.
5. Calibrate your boilers frequently. When no one is working for 8 hours or longer, turn off water heaters and air conditioning.
6. Send for Florida's tips on how to save money and energy where you work.

Write: Save it at work, The Capitol, Tallahassee, Florida 32301.

In today's world, energy is everything. Save it at work. Save it, Florida.



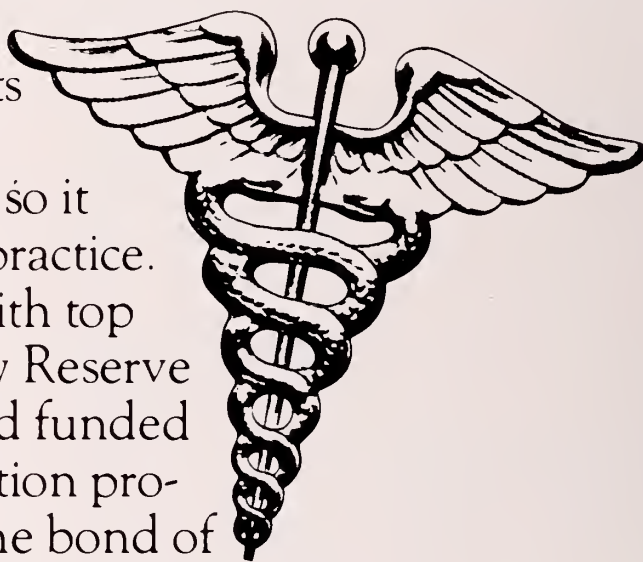
SAVE IT, FLORIDA.

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This message brought to you by
The Governor's Energy Office
and this publication.

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As an Army Reserve physician, you can serve your country and community with just a small investment of your time. You will broaden your professional experience by working on interesting medical projects in your community. Army Reserve service is flexible, so it won't interfere with your practice. You'll work and consult with top physicians during monthly Reserve meetings. You'll also attend funded continuing medical education programs. You will all share the bond of being civic-minded physicians who are also commissioned officers. One important benefit of being an officer is the non-contributory retirement annuity you will get when you retire from the Army Reserve. To find out more, simply call the number below.



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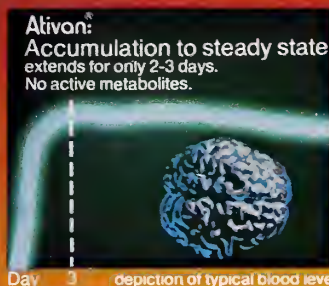
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shorter acting, less accumulation

Unlike most benzodiazepines, Ativan has a short half-life, no active metabolites, and accumulation to steady state extends for only 2-3 days. Ativan is therefore less likely to cause excessive sedation.*

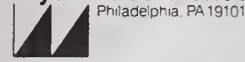
no interaction with drugs metabolized by P450 enzymes

Because it is metabolized by simple conjugation rather than complex oxidative reactions, Ativan does not compete with other drugs for hepatic P450 microsomal enzymes. Concomitant use with Tagamet® (cimetidine), for example, does not result in delayed clearance or increased sedation*—effects which have been reported with other benzodiazepines.¹⁻⁵

greater control of therapy

The short half-life of Ativan facilitates more rapid response to dosage adjustments, aiding you in titrating therapy to the patient's changing needs. Once you decide to discontinue Ativan, it will be out of your patient's system 4 days after the final dose—unlike the long-acting, multi-metabolite benzodiazepines which take as long as 2 weeks to be totally eliminated.

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References:

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Pharmacokinetics cannot as yet be directly related to efficacy.

*All benzodiazepines produce additive effects when given with CNS depressants such as barbiturates or alcohol.

See important information on following page.

Ativan®
for (lorazepam) **Anxiety**

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid over-sedation. Terminate dosage gradually since abrupt withdrawal of any anti-anxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown, but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia, some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chloridiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions: If they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan[®] for (lorazepam) _{an} Anxiety

Dosage: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

How Supplied: 0.5, 1.0 and 2.0mg tablets.

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Precautions: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

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5,000,000 hospital patients with infections.⁴ Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.³

The incalculable millions on calorie-reduced diets. Patients ingesting 1000 or fewer calories per day could be at high risk because this intake may not supply most nutrients in adequate amounts without supplementation.⁵



minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

Dosage and Administration: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.

How Supplied: Golden yellow, capsule-shaped tablets—bottles of 100.

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Berocca Plus

A balanced formula for prophylactic or therapeutic nutritional supplementation.

Berocca Plus Tablets provide: therapeutic levels of ascorbic acid and B-complex vitamins; supplemental levels of biotin, vitamins A and E, and five important minerals (iron, chromium, manganese, copper and zinc); plus magnesium. Berocca Plus is not intended for the treatment of specific vitamin and/or mineral deficiencies.

Berocca Plus,

highly acceptable to

patients, has virtually no odor or aftertaste and is economical. And its "Rx only" status means more physician involvement, better patient compliance.

References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease*, op. cit., p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, op. cit., pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med* 89 (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

candidates for

Rx ONLY

Berocca[®] Plus TABLETS

THE MULTIVITAMIN/MINERAL FORMULATION

Pinworms work the night shift



Artist's interpretation:

The nocturnal egg-laying of the female pinworm causes acute perianal itch...making children shift sleeplessly through the night.

Put pinworms out of work...

Promptly paralyzes pinworms and roundworms

Antiminth® (pyrantel pamoate) has a unique, rapid immobilizing effect on worms. Unlike mebendazole, which blocks glucose uptake—slowly “starving” helminths to death—Antiminth quickly acts on the neuromuscular junction to promptly paralyze parasites.

97% efficacy with a single dose

A single dose of Antiminth delivers rapid clinical and parasitological cures, “Single doses... showed high overall efficacy against *Enterobius vermicularis* (97.2%) and *Ascaris lumbricoides* (97.5%).”¹

Simple, well tolerated therapy

Antiminth offers ease of administration and patient tolerance. “...when compared to the other single dose agents available, [Antiminth] has the advantage of being non-staining and may be better tolerated.”²

The dosage form children like

Antiminth is available as a pleasant tasting, caramel-flavored oral suspension. Effective in just



one dose against pinworm and roundworm—in both children and adults—Antiminth is easy-to-administer and easy-to-take.

Respected around-the-world

In some parts of the world, large populations are afflicted with helminthic infections. Physicians in endemic areas have become experts on parasitic diseases—and have come to rely on Antiminth for the rapid cure of infestations. Antiminth is recommended as an agent of first choice for pinworm and roundworm by leading medical authorities.³

Warnings

Usage in Pregnancy Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions

Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions

The most frequently encountered adverse reactions are related to the gastrointestinal system. Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

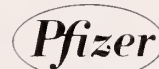
CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration

Children and Adults Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

References 1. Pitts NE, Migliardi JR: *Clinical Pediatrics* 13:87, 1974. 2. Modell W: *Drugs of Choice* 1980-1981. C. V. Mosby Co., St. Louis, 1980, p. 362. 3. Goodman LS, Gilman A: *The Pharmacologic Basis of Therapeutics*, 6th edition, MacMillan Publishing Co., Inc., New York, 1980, p. 1032.



Pfipharmecs Division

Pfizer Inc. New York, N.Y. 10017

Prescribe Antiminth® Suspension
(pyrantel pamoate) 50 mg pyrantel base/ml

Cures pinworm and roundworm fast...with a single dose



August 1982 Vol. 69, No. 8

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COVER

The August cover features the historical Robb House in Gainesville, home of the Alachua County Medical Society and Auxiliary. Purchased by Drs. Robert Lee and Sarah Lucretia Robb in 1898, the house, after several interval ownerships, is once again in medical hands. The Robb House Committee, chaired by Mark V. Barrow, M.D., Ph.D., has written an article on this stately old house which begins on page 681 of this historical issue. The photographer is O. Frank Agee, M.D.

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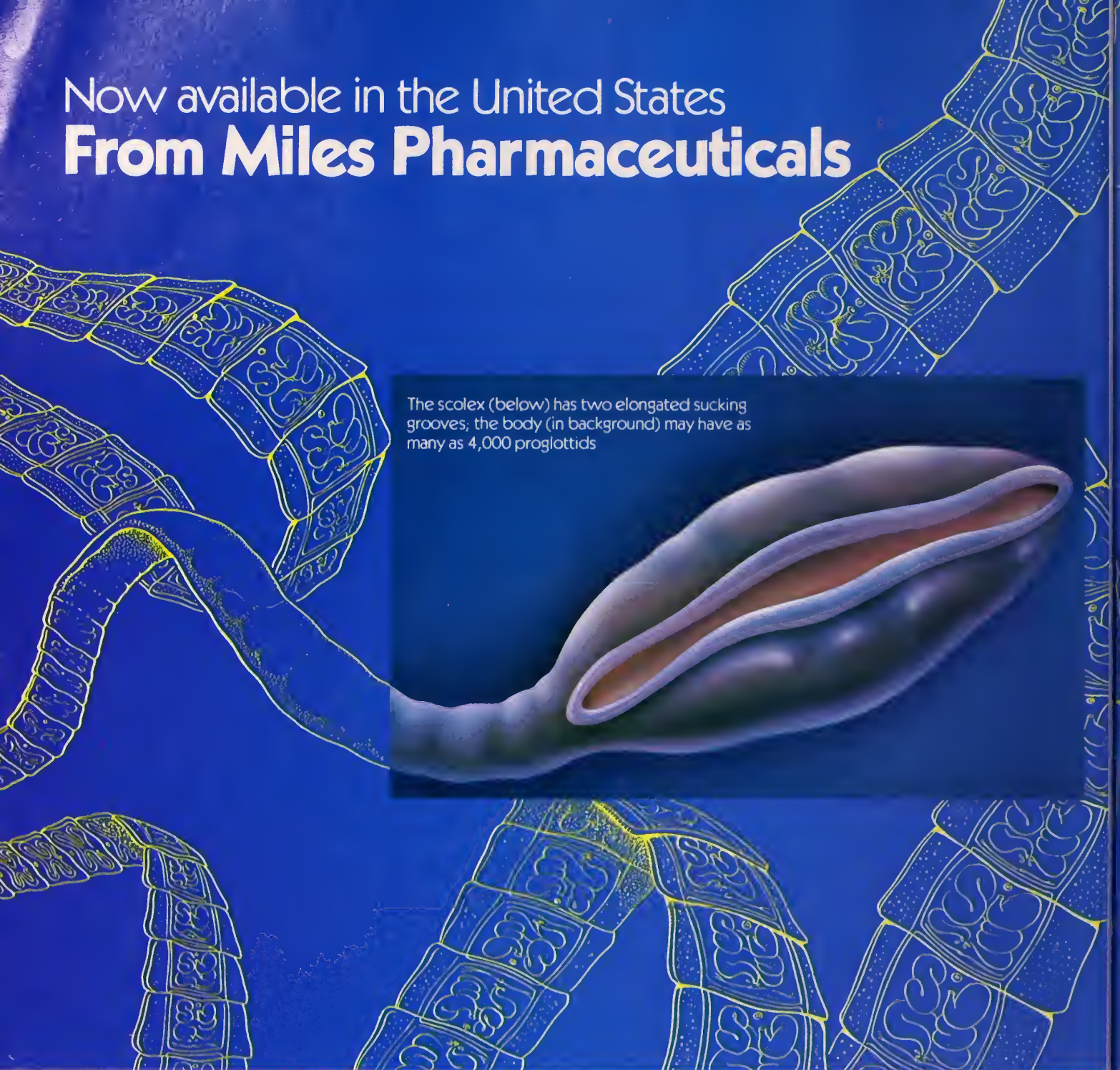
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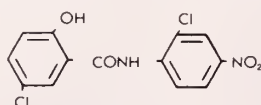
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Now available in the United States From Miles Pharmaceuticals



The scolex (below) has two elongated sucking grooves; the body (in background) may have as many as 4,000 proglottids

DESCRIPTION: NICLOCID (nicslosamide) is an anthelmintic provided in chewable tablet form at a strength of 500 mg per tablet. Nicslosamide is 2', 5'-Dichloro-4'-nitrosalicylanilide. The empirical formula is $C_{13}H_8Cl_2N_2O_4$ with the following structural formula



CLINICAL PHARMACOLOGY: NICLOCID inhibits oxidative phosphorylation in the mitochondria of cestodes. Both *in vitro* and *in vivo*, the scolex and proximal segments are killed on contact with the drug. The scolex of the tapeworm, loosened from the gut wall, may be digested in the intestine, and thus may not be identified in the feces even after extensive purging. The use of NICLOCID has not been associated with the development of anemia, leukopenia or thrombocytopenia nor have there been any effects on normal renal and hepatic functions.

INDICATIONS AND USAGE: NICLOCID (nicslosamide) is indicated for the treatment of tapeworm infections by *Taenia saginata* (beef tapeworm), *Diphyllobothrium latum* (fish tapeworm) and *Hymenolepis nana* (dwarf tapeworm).

CONTRAINDICATIONS: NICLOCID™ Tablets are contraindicated in individuals who have shown hypersensitivity to any of its components.

PRECAUTIONS: NICLOCID affects the cestodes of the intestine only. It is without effect in cysticercosis.

Drug Interactions: No data are available regarding interaction of nicslosamide with other drugs.

Carcinogenesis, Mutagenesis, Impairment of fertility:

Carcinogenicity Potential: Although carcinogenicity studies on nicslosamide *per se* have not been done, long-term feeding studies on its ethanolamine salt in rats and mice did not show carcinogenicity. Mutagenicity tests have not been performed.

Pregnancy: Pregnancy Category B: Reproduction studies in rabbits and rats at doses of 25 times the human therapeutic dose and in mice at 12 times the human therapeutic dose, have revealed no evidence of impaired fertility or harm to the fetus due to nicslosamide. There are, however, no adequate and well-controlled studies in pregnant women. Because animal studies are not always predictive of human response, the drug should be used during pregnancy only if clearly needed.

Nursing Mothers: No studies are available.

Pediatric Use: In children under 2 years of age, the safety of the drug has not been established.

ADVERSE REACTIONS: The incidence of side effects has been reported as follows: nausea/vomiting 4.1%, abdominal discomfort including loss of appetite 3.4%, diarrhea 1.6%, drowsiness, dizziness, and/or headache 1.4%, and skin rash including pruritus and 0.3%. Other side effects listed in decreasing order of frequency were: oral irritation, fever, rectal bleeding, weakness, bad taste in mouth, sweating, palpitations, constipation, alopecia, edema of an arm, backache and irritability. There was also one instance of a transient rise in SGOT in an i.v. narcotic addict. Two cases of urticaria reported may be

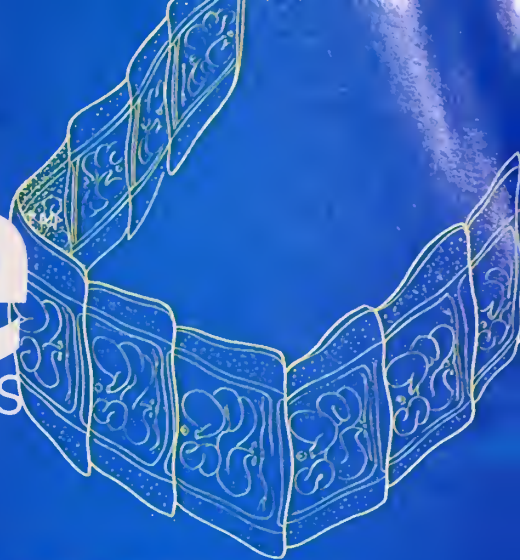
related to the breakdown products of the tapeworm. All side effects were mild or moderate and transitory and did not necessitate discontinuation of the treatment.

OVERDOSAGE: Insufficient data are available. In the event of overdose a fast-acting laxative and enema should be given. Vomiting should not be induced.

DOSAGE AND ADMINISTRATION:

1. *Taenia saginata* and *Diphyllobothrium latum*
 - a. Adults: 4 tablets (2.0 g) chewed thoroughly in a single dose
 - b. Children weighing more than 34 kg (75 lbs): 3 tablets (1.5 g) chewed thoroughly in a single dose.
 - c. Children weighing between 11 and 34 kg (25 to 75 lbs): 2 tablets (1.0 g) chewed thoroughly in a single dose
 2. *Hymenolepis nana*
 - a. Adults: 4 tablets (2.0 g) chewed thoroughly as a single daily dose for 7 days.
 - b. Children weighing more than 34 kg (75 lbs): 3 tablets (1.5 g) chewed thoroughly on the first day, then 2 tablets (1.0 g) daily for next 6 days.
 - c. Children weighing between 11 and 34 kg (25 to 75 lbs): 2 tablets (1.0 g) to be chewed thoroughly on the first day, then one tablet (0.5 g) daily for next 6 days.
- T. saginata* and *D. latum* infections are usually due to a single adult worm and require an intermediate host in their life cycle. With *Hymenolepis nana* multiple infections are the rule. No intermediate host is required, both larval and adult stages of the worm may be found in the human intestine where the complete life cycle occurs. Since the drug is more effective against the

NEW Prompt-Action **NICLOCIDE** NICLOSAMIDE CHEWABLE TABLETS 500 mg.



A safe, reliable single-dose taeniocide that eradicates beef and fish tapeworms in a single day

Highly effective prompt taeniocidal action

NICLOCIDE™ (niclosamide) is considered as the drug of choice in eliminating beef tapeworm (*Taenia saginata*), fish or broad tapeworm (*Diphyllobothrium latum*), and dwarf tapeworm (*Hymenolepis nana*) from the intestines. Except for the dwarf tapeworm, which requires a seven-day treatment (SEE FULL PRESCRIBING INFORMATION BELOW), a one-day single-dose treatment is sufficient to kill these cestodes.

Breaks hold of head and chain of segments

NICLOCIDE works promptly and simply. After tablets are chewed thoroughly and washed down with a little water (for children tablets should be pulverized and mixed

with a little water), the insoluble micronized crystals act by direct contact on the tapeworm head. As soon as NICLOCIDE reaches the parasite, the scolex and upper segments are killed, thus depriving the whole chain of its hold. It is then discharged in stool either in one piece or smaller portions.

Safe and well tolerated/ little gastrointestinal mucosa irritation

NICLOCIDE has proved exceptionally well accepted by adults as well as children weighing more than 11 Kg. (25 lbs.).

Convenient one-day single-dose administration*

NICLOCIDE Tablets are taken as a single dose after breakfast. Tablets must be chewed or pulverized thoroughly and washed down with a little water. No special diet or preparation is necessary except in patients who are constipated. In these cases, a thorough cleansing of the bowels may be required before treatment. The avoidance of alcohol during treatment is the only other requirement.

*A drastic saline purge, such as magnesium sulfate or sodium sulfate should be given two hours after the NICLOCIDE dose if it is required that the tapeworms be expelled rapidly and in one piece.

*In infections with beef tapeworm (*T. saginata*) and fish tapeworm (*D. latum*) one single dose is sufficient, for infections with dwarf tapeworms (*H. nana*) a seven-day treatment is recommended (SEE FULL PRESCRIBING INFORMATION ON THESE PAGES).

mature than the larval stage, therapy must be extended over several days to cover all stages of maturation. Patients with *H. nana* must be instructed to observe strict personal and environmental hygiene to avoid autoinfection with this parasite.

3. NICLOCIDE™ must be thoroughly chewed and then swallowed with a little water. No special dietary restrictions are necessary before or after treatment. The best time to take the drug is after a light meal (e.g., breakfast). A mild laxative may be desirable in constipated patients to achieve a normal bowel movement. Young children should have the tablets crushed to a fine powder and mixed with a small amount of water to form a paste.

NICLOCIDE has a vanilla taste which is not unpleasant to most persons.

NICLOCIDE is suitable for administration on an ambulatory or outpatient basis.

4. Follow-up:

As the vermifugal action of NICLOCIDE renders the tapeworm, especially the scolex and proximal segments, vulnerable to destruction during their passage through the gut, it is not always possible to identify the scolex in stools. The sooner the tapeworm is passed and examined after treatment, the better the chance of identification of the scolex. Segments and/or ova of beef or fish tapeworm may be present in the stool for up to 3 days after therapy. Persistent *T. saginata* or *D. latum* segments and/or ova on the seventh day post therapy indicate failure. A second identical course of

treatment may be given at that time.

No patient should be considered cured unless the stool has been negative for a minimum of three months.

HOW SUPPLIED: NICLOCIDE is available as round, light yellow chewable tablets, scored on one side, embossed with the word Miles and number 721, each containing 500 mg of niclosamide, and is supplied in boxes of 4 tablets.

Storage Conditions: Store below 86°F (30°C), avoid freezing.

Manufactured by:
Bayvet Division Cutter Laboratories, Inc.
Shawnee, Kansas 66201

Distributed by:
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West Haven, Connecticut 06516

PD100551 18612 Made and printed in USA April 1982

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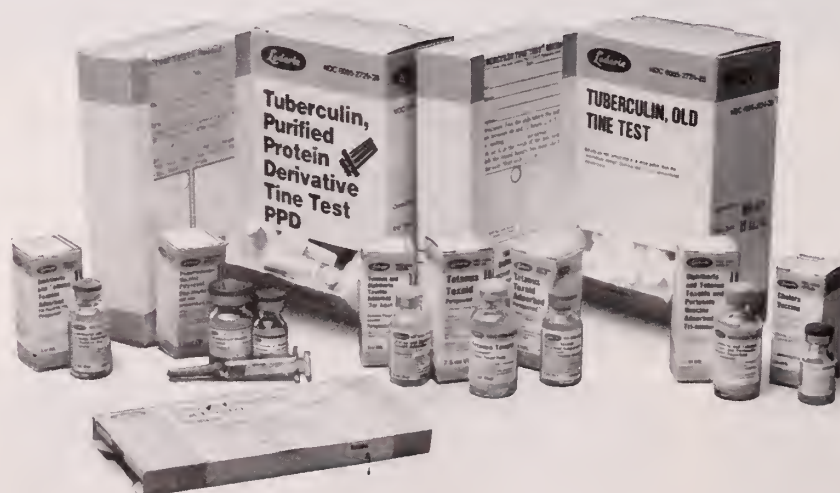
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THE CRITICAL FACTOR IN TB SCREENING

...and no easier method to confirm the results.

Lederle Tuberculin, Old, TINE TEST®

Indications: For screening for tuberculosis.

Precautions: Use with caution in persons with acute tuberculosis (activation of quiescent lesions is rare); and in patients with known allergy to acacia. Reactivity to the test may be suppressed in those receiving corticosteroids or immunosuppressive agents, or those who have recently been vaccinated with live virus vaccine such as measles, mumps, rubella, polio, etc. With a positive reaction, further diagnostic procedures must be considered, i.e., chest x-ray, microbiologic examinations of sputum and other specimens, confirmation of positive tine test (except vesiculation reactions) by Mantoux method. When vesiculation occurs, the reaction is to be interpreted as strongly positive and a repeat test by the Mantoux method must not be attempted. If a patient has a history of occurrence of vesiculation and necrosis with a previous tuberculin test by any method, tuberculin testing should be avoided. Similar or more severe vesiculation with or without necrosis is likely to occur.

Pregnancy Category C. Animal reproduction studies have not been conducted; whether Tuberculin, Old, TINE TEST® can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity is unknown. Tuberculin, Old, TINE TEST should be given to a pregnant woman only if clearly needed. During pregnancy, known positive reactors may demonstrate a negative response.

Adverse Reactions: Vesiculation, ulceration, or necrosis may appear at test site in highly sensitive persons. Pain, pruritus and discomfort at test site may be relieved by cold packs or by topical glucocorticoid ointment or cream. Any transient bleeding at puncture site is not significant.

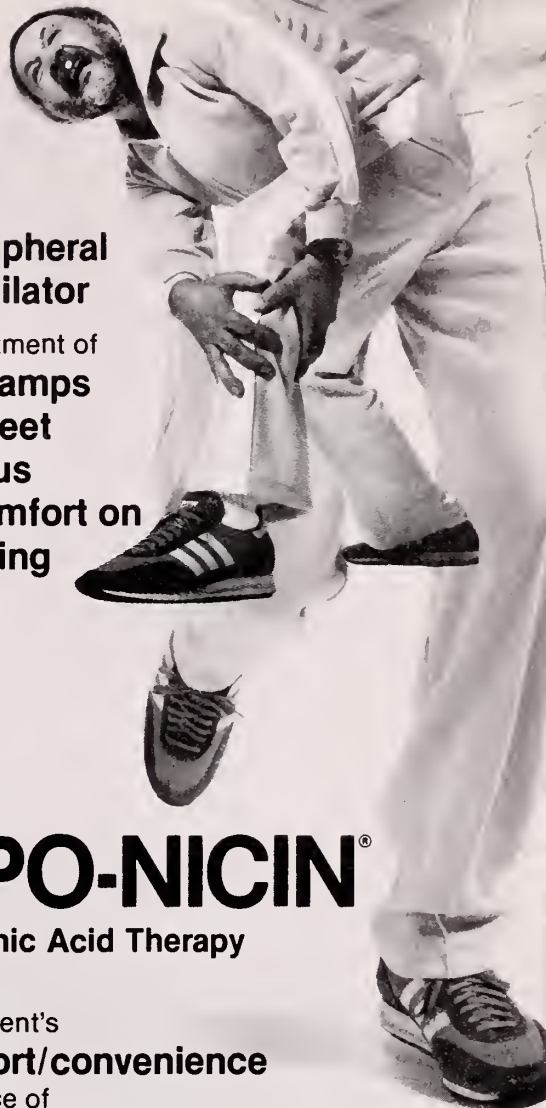


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A peripheral vasodilator

for treatment of
leg cramps
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tinnitus
discomfort on
standing



LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid	.....300 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid	.....250 mg.
Niacinamide	.....75 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid	.....100 mg.
Niacinamide	.....75 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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2500 West Sixth Street, Los Angeles, California 90057



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is the presenting
symptom...**

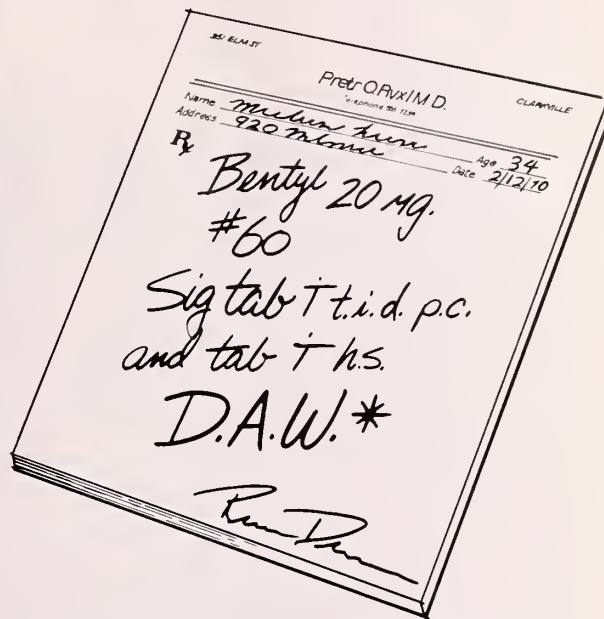


...in the functional bowel/irritable bowel syndrome*

be sure to specify

Bentyl[®]
(dicyclomine hydrochloride USP)

10 mg capsules, 20 mg tablets,
10 mg/5 ml syrup, 10 mg/ml injection



**D.A.W.-Dispense as written*

because:

- ⊕ The Bentyl molecule is a product of original Merrell research.
- ⊕ At Merrell Dow, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- ⊕ Bentyl bioavailability of tablets, capsules, syrup and injectable is evidence of its prompt absorption.
- ⊕ Bentyl helps control abnormal gastrointestinal motor activity with minimal anticholinergic side effects. (See Warnings, Contraindications, Precautions, and Adverse Reactions on next page.)
- ⊕ The bioequivalence of the oral dosage forms permits a choice of tablet, capsules, or syrup that satisfies patient's dosage preferences.
- ⊕ Significant pharmacologic effect in the distal colon compared to placebo,¹ shows how Bentyl controls abnormal motor activity in the irritable colon patient.*

*This drug has been classified "probably" effective for this indication.

Merrell Dow

Reference:

1. Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

Although the dose of Bentyl used to show pharmacologic effect was 50 mg, which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg (2 ml) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®**(dicyclomine hydrochloride USP)**Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION
Brief Summary**INDICATIONS**

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FOA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.**WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.**PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.**DOSAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.**Usual Dosage**Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.**NOT FOR INTRAVENOUS USE****MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of July, 1980

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ONE FOR ALL – One tablet treats pinworm
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Obviates need to calculate individual dosages.

A single tablet eradicates pinworm in 95% of patients.

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DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. In man, approximately 2% of administered mebendazole is excreted in urine as unchanged drug or a primary metabolite. Following administration of 100 mg of mebendazole twice daily for three consecutive days, plasma levels of mebendazole and its primary metabolite, the 2-amine, never exceeded 0.03 µg/ml and 0.09 µg/ml, respectively.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.

VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

US Patent 3,657,267
December 1979

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References: 1. Williams RL, Karacan I: Introduction, chap. 1, in *Sleep Disorders: Diagnosis and Treatment*, edited by Williams RL, Karacan I, Frazier SH. New York, John Wiley & Sons, 1978, p. 2. 2. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 3. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 4. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. 5. Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 6. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 7. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Dement WC et al: *Behav Med* 5(10):25-31, Oct 1978. 10. Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 11. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. 12. Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. 13. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 14. Kales A, Kales JD: *Pharmacol Physicians* 4(9):1-6, Sep 1970. 15. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

The Physician's Sleep Glossary

Some common sleep laboratory terms

poly·som·no·graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la·ten·cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af·ter sleep on·set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to·tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.¹

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.²

re·bound in·som·nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.³

Efficacy objectively demonstrated in the sleep laboratory—the most valid environment for measuring hypnotic efficacy.

In numerous sleep laboratory investigations patients fell asleep sooner, slept longer and woke up less during the night³⁻¹² with

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Compared with temazepam and other hypnotics, onset of sleep is more rapid⁴ with

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Rebound insomnia is avoided upon discontinuation^{3,4,7} of

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Low incidence of morning "hang-over"¹⁴ with

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The efficacy of Dalmane has been studied in over 200 clinical trials with more than 10,000 patients.³⁻¹⁵ During long-term therapy, which is rarely required, periodic blood, kidney and liver function tests should be performed. Contraindicated in patients who are pregnant or hypersensitive to flurazepam.

Please see summary of product information on following page.



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Manati, Puerto Rico
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Dalmane[®] (flurazepam HCl/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, light-headedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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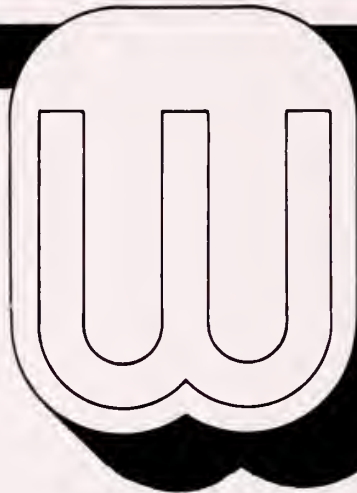
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A conflict of interest or a time for action

Certain of those physicians in South Florida who recently experienced a potentially severe financial crisis regarding their professional liability insurance have accused the FMA of a conflict of interest in sponsoring and endorsing the Florida Physicians' Insurance Reciprocal which insures physicians for professional liability.

The FMA has sponsored a group program for professional liability insurance almost continuously since 1929. Early in the 50's the FMA leadership recognized the medical liability problem had worsened in California and New York and would probably be spreading to Florida in the near future.

Through careful planning for 10 years with expertise from many areas, a comprehensive program was developed and implemented in the early 60's. The program features included central coordination of legal counsel, coordination of claims, peer underwriting, loss prevention, and risk management.

In 1975 when availability of professional liability insurance was nil from commercial companies in Florida, the FMA leadership had a choice of doing nothing or creating a vehicle for professional liability insurance. The FMA Board of Governors with approval of the House of Delegates, acted in a responsible manner to help meet the needs of its membership and authorized the creation of the FMA PLI Trust and its successor, the Reciprocal — independent of the Government for its basic coverage, reinsurance, and excess coverage.



Some physicians followed the advice of hospital administrators, attorneys, and others and formed the Trusts independent of the FMA program and depended upon the Government operated Patient's Compensation Fund which now faces financial problems as predicted.

Now where is the conflict? Is it the FMA which acted in a responsible manner, its activities approved by both its executive (Board of Governors) and its legislative (House of Delegates) branches to provide professional liability coverage? Or is it those physicians who sought to solve their liability problems elsewhere which resulted in a dismal, financial quagmire dependent on Government for a subsidy or solution?

I believe the conflict of interest statement about the FMA is patently unfair.

The entire medical profession, particularly that of Florida, faces a tremendous crisis as the escalation of cost for professional liability insurance continues to increase in the immediate future. Rampant, jumbo awards which should shock the conscience of our judicial system are becoming a commonplace event.

The FMA is finalizing a dynamic program for consideration by the Florida Legislature. I trust every member of the FMA, regardless of where he obtains his professional liability insurance coverage, will realize the serious problems facing us and devote time and energy towards the successful implementation of our program. Only through a united effort will our elected representatives respond.

History has shown repeatedly the debilitating effects on conflicting and divisive approaches to resolving mutual problems. Let us benefit from history and mobilize our strength to attack a serious situation that not only affects the medical profession but also many others facing personal injury liability.

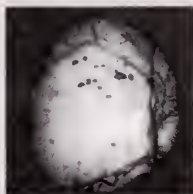
Robert E. Wadson, M.D.

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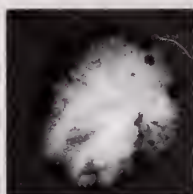
The Problem

SYMPTOMS:

EARLY INTERSTITIAL CYSTITIS



CLASSICAL INTERSTITIAL CYSTITIS



- ☐ irritative voiding symptoms
- ☐ suprapubic pain
- ☐ functional bladder capacity reduced
- ☐ anatomical bladder capacity:
 - EARLY — normal
 - CLASSICAL — reduced
- ☐ vesical mucosa:
 - EARLY — normal appearing
 - CLASSICAL — ulcerated, scarred
- ☐ submucosal vesical hemorrhages observed following second overdistension

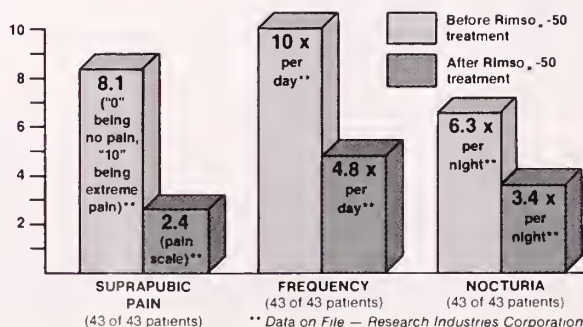
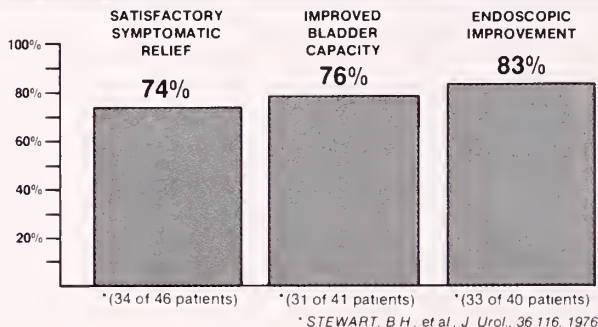
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INDICATIONS AND USAGE: Rimso-50 (dimethyl sulfoxide) is indicated for the symptomatic relief of patients with interstitial cystitis. Rimso-50 has not been approved as being safe and effective for any other indication. There is no clinical evidence of effectiveness of dimethyl sulfoxide in the treatment of bacterial infections of the urinary tract.

CONTRAINDICATIONS: None known.

WARNINGS: Dimethyl sulfoxide can initiate the liberation of histamine and there has been occasional hypersensitivity reaction with topical administration of dimethyl sulfoxide. This hypersensitivity has been reported in one patient receiving intravesical Rimso-50. The physician should be cognizant of this possibility in prescribing Rimso-50. If anaphylactoid symptoms develop, appropriate therapy should be instituted.

PRECAUTIONS: Changes in the refractive index and lens opacities have been seen in monkeys, dogs and rabbits given high doses of dimethyl sulfoxide chronically. Since lens changes were noted in animals, full eye evaluations, including slit lamp examinations, are recommended prior to and periodically during treatment. Approximately every six months patients receiving dimethyl sulfoxide should have a biochemical screening, particularly liver and renal function tests, and complete blood count.

Intravesical instillation of Rimso-50 may be harmful to patients with urinary tract malignancy because of dimethyl sulfoxide-induced vasodilation. Some data indicate that dimethyl sulfoxide potentiates other concomitantly administered medications.

Pregnancy Category C: Dimethyl sulfoxide caused teratogenic responses in hamsters, rats, and mice when administered intraperitoneally at high doses (2.5-12 gm/kg). Oral or topical doses of dimethyl sulfoxide did not cause problems of reproduction in rats, mice and hamsters. Topical doses (5 gm/kg first two days, then 2.5 gm/kg - last eight days) produced terata in rabbits, but in another study, topical doses of 1.1 gm/kg days 3 through 16 of gestation failed to produce any abnormalities. There are no adequate and well controlled studies in pregnant women. Dimethyl sulfoxide should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when dimethyl sulfoxide is administered to a nursing woman.

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: A garlic-like taste may be noted by the patient within a few minutes after instillation of Rimso-50 (dimethyl sulfoxide). This taste may last several hours and because of the presence of metabolites, an odor on the breath and skin may remain for 72 hours.

Transient chemical cystitis has been noted following instillation of dimethyl sulfoxide. The patient may experience moderately severe discomfort on administration. Usually this becomes less prominent with repeated administration.

DOSAGE AND ADMINISTRATION: Instillation of 50 ml of Rimso-50 (dimethyl sulfoxide) directly into the bladder may be accomplished by catheter or aseptic syringe and allowed to remain for 15 minutes. Application of an analgesic lubricant gel such as lidocaine jelly to the urethra is suggested prior to insertion of the catheter to avoid spasm. The medication is expelled by spontaneous voiding. It is recommended that the treatment be repeated every two weeks until maximum symptomatic relief is obtained. Thereafter, time intervals between therapy may be increased appropriately.

Administration of oral analgesic medication or suppositories containing belladonna and opium prior to the instillation of Rimso-50 can reduce bladder spasm.

In patients with severe interstitial cystitis with very sensitive bladders, the initial treatment, and possibly the second and third (depending on patient response) should be done under anesthesia (Saddle block has been suggested).

HOW SUPPLIED:

Bottles contain 50 ml of sterile and pyrogen-free Rimso-50 (50% w/w dimethyl sulfoxide aqueous solution).

Dimethyl sulfoxide is clear and colorless.

Protect from strong light.

Store at room temperature (15° to 30° C).

Do not autoclave.

NDC #0433-0433-05

*Stewart, B.H., et al., J. Urol., 36:116, 1976

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What is history?

Is it the intrinsic truth of immeasurable biographies, philosophy learned from examples, nothing more than belief in the senses, belief in falsehoods, more or less "bunk", or is it in essence a compilation of ideas? History says, "If it pleases, excuse me, I beg your pardon, it will never happen again if I can help it."

Whatever definition one accepts, it often appears that people and governments learn little from history or act on principles deduced from it. And the most important of all lessons that history has to teach is that men do not learn much from the lessons of history. Yet logically or philosophically, the future can be charted wisely and more clearly only when better known is the path which has led to the present. To be ignorant of what occurred before one's birth is to remain always a child, for what is the worth of human life unless it is woven into the lives of our ancestors by the records of history? Wherever and whenever men have lived, there is a story to be told and future, perhaps wiser, generations will be dependent on today's historian whose task it is to record events truthfully as he collects them. So, it is our duty to encourage historiologists and preserve their narrations.

Once again, we are indebted to Bill Straight, an exact story-teller, who, thoroughly comprehending history, interestingly furnishes something of the experiences he has acquired by being a contemporary of all ages and a fellow citizen of all peoples.

*Clyde M. Collins, M.D.
Associate Editor
Jacksonville*

Greedy doctors or greedy lawyers?

A physician's reply to a lawyer

The Miami Lawyer, [Mr. Jose Smith] who wrote the letter on Medical Malpractice published in the Miami Herald on June 12th, is at the very least a master of deception.

Among other things, he states that "the contingent-free contract is the poor man's key to the courthouse." When in reality, it is the attorney's easy ride to riches.

It would take 49 years of hard work for a hypothetical physician earning \$100,000 per year to earn the 4.9 million dollars recently pocketed by a Broward County Lawyer in a single case.

If trial lawyers are so concerned about poor people, they should render their services free as many doctors do.

Trial lawyers also defend their right to contingency fees on the basis that they provide a great service to their clients. Clearly, the greatest service rendered to a person is the preservation of his life. Doctors do this every day and they do not claim 45 percent of their patient's wealth.

To those who think doctors are "greedy", I invite them to conduct an independent audit of a physician's and any other professional's Accounts Receivable and verify who is left with more unpaid bills; and of course, doctors do not demand advance "retainer" fees for their services, as lawyers do, when their appetite is not fed by the prospects of a fat contingency fee.

Unfortunately, trial lawyers are rapidly succeeding in transforming America into the home of the cheater and the land of the lawsuit. Their ripoff is not limited to the field of medical malpractice. Under the false pretense of "defending" the constitutional rights of the people, they seek to perpetuate a liability judicial system which makes them millionaires overnight.

In the meantime, we all pay through higher consumer prices and higher insurance rates.

Something has to be done to stop this nonsense or we will soon live in a country where everybody is suing somebody, while the economic structure of the nation collapses under our feet.

Trial lawyers' spokesmen cynically are laying the malpractice insurance crisis on the incompetence and negligence of the medical profession. The truth of the matter is that we deliver the best medical care available in the world. If not, who among us would like to get sick in another country?

I urge the people of Florida to support a change in the legal system dealing with so-called "medical malpractice" because it is insane and unjust.

Today physicians see themselves treated like criminals in court and punished with the threat of financial disaster when they cannot deliver a miraculous cure.

Jurors, who are unqualified to understand the complexities of medical care, are handing out verdicts of medical malpractice where none exist. These

judgements are followed by outrageous "jumbo" awards, sanctioned by biased judges, some of whom rule against existing law and "de facto" exercise more power than a king in the middle ages.

Very simply, if the present system is allowed to continue, many physicians will have to close their practices or move to another State where sanity still exists. Then, when somebody here feels sick during the weekend, instead of calling his "greedy doctor" on a Saturday night, he will have to contact his "humanitarian lawyer" on a Monday morning.

*Carlos J. Dominguez, M.D.
Miami Beach*



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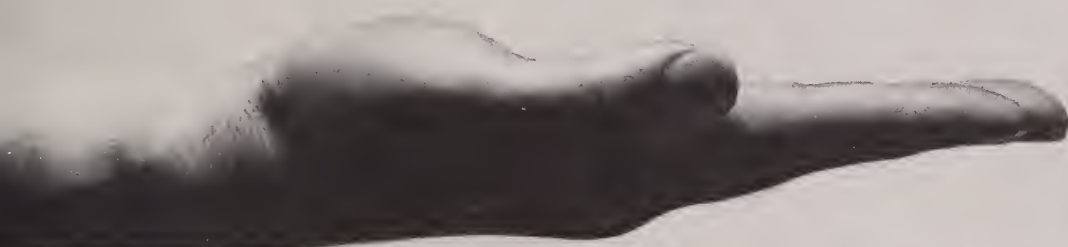
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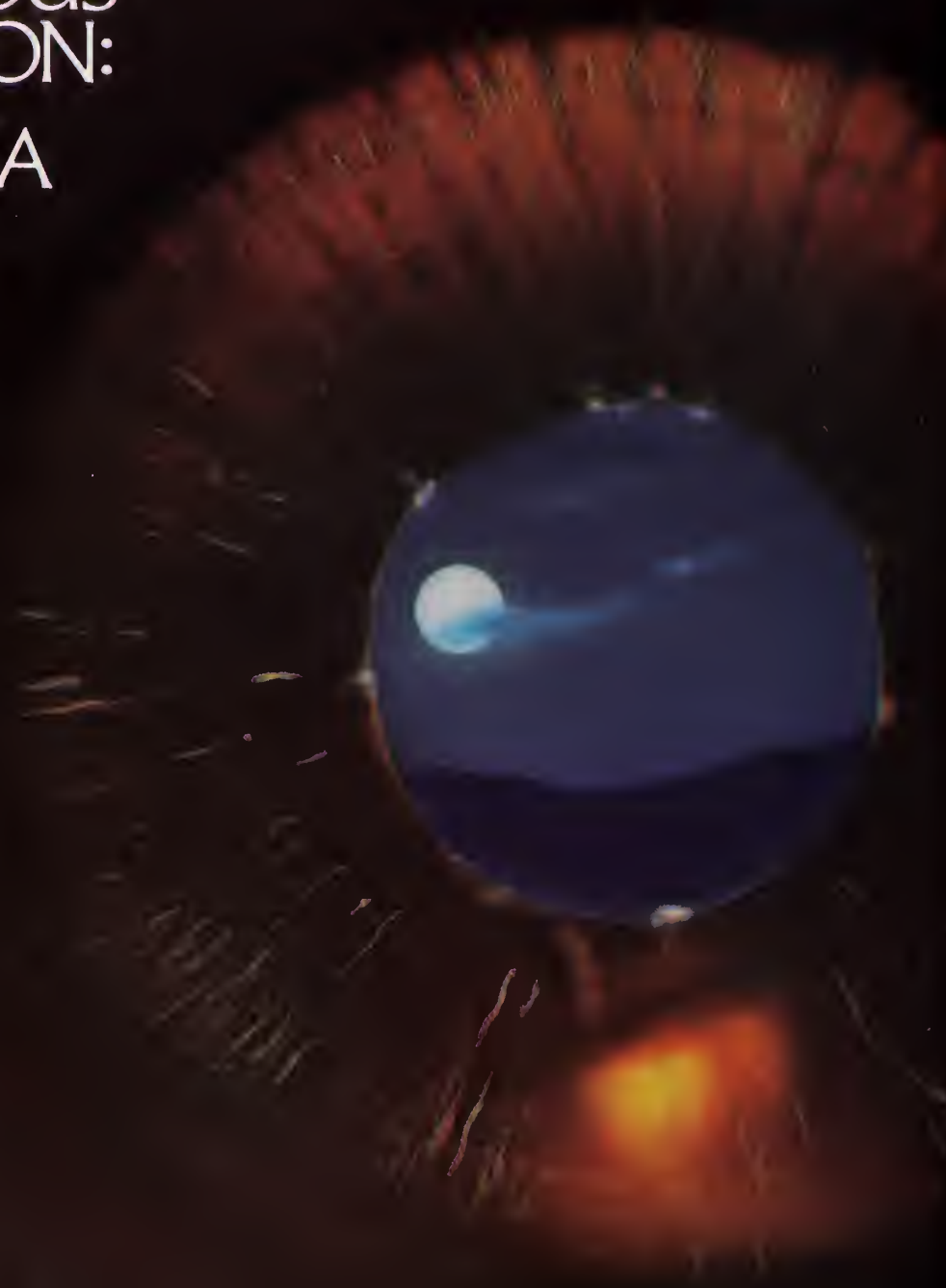
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ONE OF THE VITAL SIGNS OF ANXIOUS DEPRESSION: INSOMNIA

Others to look for:

agitation
anorexia
feelings of guilt
and worthlessness
fatigue
palpitations
headache
vague aches
and pains
sadness
psychic and
somatic anxiety

Artist's conception,
looking out from the human eye
as conceived in a schematic model.



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Limbitrol brings a special—and specific—quality of relief to most anxious depressed patients. Insomnia, for example, responds with particular promptness. Other symptoms likely to respond within the first week of treatment include anorexia, agitation and psychic and somatic anxiety. And, as the depression and anxiety are alleviated, in many cases so are such related somatic symptoms as headache, palpitations, and various vague aches and pains.

Limbitrol given once daily h.s. may be the best approach

Many patients respond readily to a single bedtime dose of Limbitrol, a convenient schedule that may enhance compliance and helps relieve the insomnia associated with anxious depression. Limbitrol also offers a choice of other regimens: t.i.d., or a divided dose with the larger portion h.s. In all cases, caution patients about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as driving or operating machinery.

in moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg clordiazepoxide and 12.5 mg amitriptyline
(as the hydrochloride salt)

Tablets 10-25 each containing 10 mg clordiazepoxide and 25 mg amitriptyline
(as the hydrochloride salt)

Specific therapy with h.s. dosage convenience

Please see summary of complete product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses.) Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies.

Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated. Sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecostasia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50.

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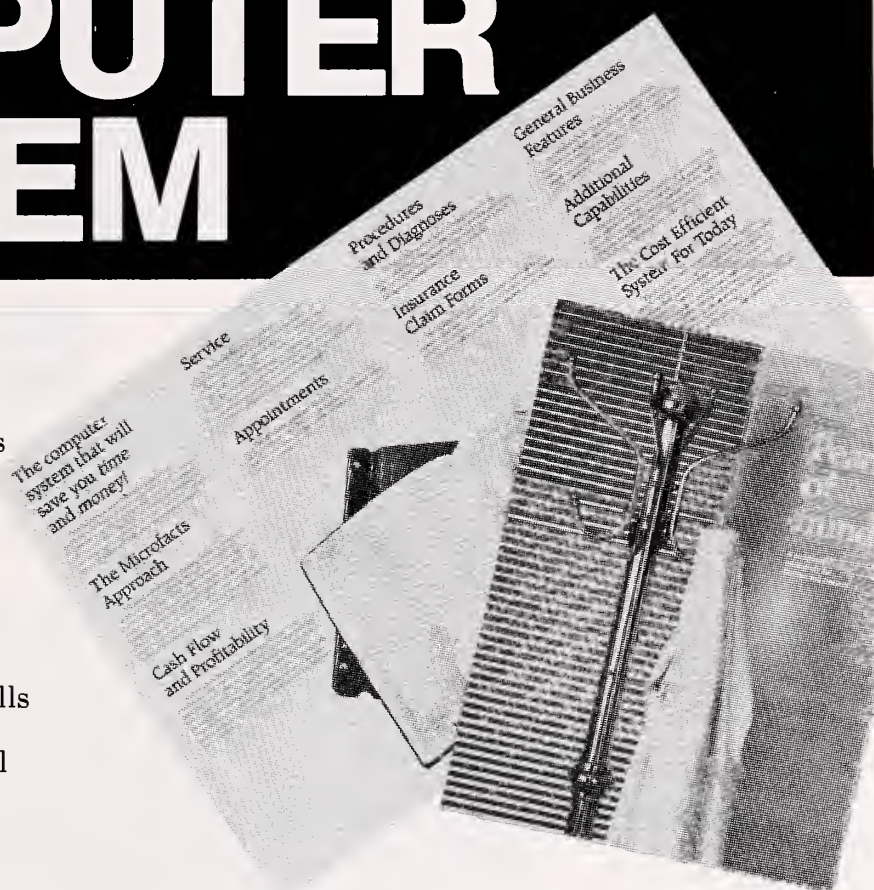
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An added complication... in the treatment of bacterial bronchitis*



Brief Summary

Consult the package literature for prescribing information.

Indications and Usage: Cefclor* (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefclor.

Hypersensitivity reactions have been reported in about 1.5

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefclor

Pulvules®, 250 and 500 mg

percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefclor* (cefclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain: Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). (1002818)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

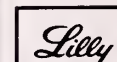
Note: Cefclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

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5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), 11:880. Washington, D.C.: American Society for Microbiology, 1978.
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8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc. Carolina, Puerto Rico 00630.



Historical Issue

William M. Straight, M.D.,
Historical Editor

In this issue...

The feature article of this historical issue is on the history of Alachua County medicine by Mark V. Barrow Sr., M.D., of Gainesville. Although a cardiologist, he has an abiding interest in Florida medical history. In this issue he traces medicine from the first Spanish and French contacts with the Indians to the turn of the present century. Much of his information has not been previously published.

In conjunction with Dr. Barrow's article is an account of the restoration of a Victorian cottage in Gainesville to serve as the home of the Alachua County Medical Association and its Auxiliary. This nineteenth century cottage was once the home of Drs. Robert Lee Robb and Sarah Lucretia Robb, a husband-wife medical team.

The third article in this issue is a biographical sketch of the eleventh president of the Florida Medical Association, Dr. N.D. Phillips of Gainesville. The author of this sketch, Dr. E. Ashby Hammond, is Professor Emeritus of History at the University of Florida. Dr. Hammond is the author of a number of articles dealing with Florida medical history, some of which have appeared in past historical issues of *The Journal*.

The fourth paper also comes from Gainesville. The author, Todd L. Savitt, Ph. D., has just completed several years as Associate Professor and Acting Chief of the Division of Social Sciences and Humanities at the College of Medicine, University of Florida.

Long interested in the medical care of plantation slaves he brings us a number of letters from plantation owners of Albemarle County, Virginia, to a Charlottesville physician, Dr. Charles Brown. These letters give an insight into the medical practices in the early nineteenth century.

A newcomer to the Historical Issue, William Cox, M.D., County Health Officer of Collier County, brings us the first published account of the medical history of Collier County. Dr. Cox traces medical practices from the prehistoric inhabitants of Southwest Florida to the present time with its influx of Cuban and Haitian refugees.

Physicians who began their practice in Florida in the depression years will be moved to reminiscences as they read the article by Franz H. Stewart, M.D. Dr. Stewart, a past editor of *The Journal of the Florida Medical Association*, skillfully sketches the life of the physician in Miami in the depth of the depression when he first "came to town".

Finally, your Historical Editor presents an account of medicine as it was practiced at Fort Dallas, an army post at the mouth of the Miami River during the Second and Third Seminole Wars. This paper is based on the monthly and quarterly reports of the surgeons who served at the post and provides a detailed look at the medical and surgical practices of that day.

We hope you will enjoy this issue.

W. M. S.

Early history of medicine in Alachua County

Mark V. Barrow Sr., M.D., Ph.D.

Medicine in the Alachua County Region begins in antiquity with American Indians. These people inhabited Northern Florida as early as 12,000 B.C.¹. In this region, man produced stone tools initially and fiber-tempered pottery somewhat later, and still later grit-tempered pottery. By the 16th and 17th centuries an agricultural base of corn, beans, pumpkins and tobacco had developed. The period called the Alachua Tradition spans from A.D. 800 to A.D. 1700.



Figure 1. — How They Treat Their Sick From le Moyne In 1564²

The Author

MARK V. BARROW SR., M.D., PH.D.

Dr. Barrow practices internal medicine and cardiology in Gainesville, and is Chairman of the Robb House Committee. (see page 681).

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Timucuan Indians • At the time the first European explorations began in Florida during the first half of the 16th century, more than 100,000 Indians inhabited the area now known as Florida. The Northern agricultural tribes were known as Timucuans and the group in present day Alachua County were known as the Potano group.

Reports of the Spanish, which began in 1513 with Ponce de Leon's discovery of Florida, and accounts of the French provide important information on the Timucuans. One of these in particular describes and illustrates medical practice among these Indians. Theodore deBry's engravings of the French colony in Florida were produced from Jacques le Moyne de Morgues, the artist who came to the New World with the Huguenots in 1564². While the chief or cacique of a region was the most important individual, others also served in important roles as priest, sorcerer, and physician. In one example, the sorcerer is consulted about an upcoming battle.

He laid the shield on the ground, drawing a circle around it and inscribing it with various signs; then, kneeling on it, he whispered some unintelligible words and made gestures as if he were engaged in animated conversation; after a quarter of an hour his appearance became so frightful that he looked scarcely human; he twisted his limbs until the bones snapped out of place and did many other unnatural things; then suddenly he became calm, stepped out of his circle, saluted his chief and revealed to him the number of the enemy and the place where they were to fight³.

A description on how they treat their sick is seen in Figure 1⁴.

They build a bench long enough and wide enough for the sick person, and he is laid upon it, either on his back or on his stomach. This depends upon the nature of his

illness. Then, cutting the skin of his forehead with a sharp shell, they suck the blood with their own mouths, spitting it out into an earthen jar or a gourd. Women who are nursing or are pregnant come and drink this blood, especially if it is that of a strong young man. They believe that drinking it makes their milk better and their children stronger, healthier, and more active.

For the sick, whom they lay face downward, a fire of hot coals is prepared, onto which seeds are thrown. The sick man inhales the smoke through his nose and mouth; this is to act as a purge, expelling the poison from the body and thus curing the disease.

They also have a plant which the Brazilians call petum and the Spaniards tapaco. After carefully drying its leaves, they put them in the bowl of a pipe. They light the pipe, and, holding its other end in their mouths, they inhale the smoke so deeply that it comes out through their mouths and noses; by this means they often cure infections.

Venereal disease is common among them, and they have several natural remedies for it.

From these and other descriptions it was obvious that the treatment of the sick varied from magic remedies to the use of medicinal herbs.

Milanich describes several types of practitioners known as curers, herbalists, midwives and priests (shamans). These practitioners utilized praying, administration of certain herbs, and use of ritual fires in conjunction with curing ceremonies. Evil spirits were removed by rituals. Midwives cured with prayers and herbs and delivered babies and administered to the women in labor⁵.

A vivid account of trauma involving Hernando de Soto • Several accounts of de Soto's travels through the Alachua area in 1539 describe de Soto's involvement with a local Chief Vitachuco, captured by the Spanish⁶.

Seven days after the recent skirmish and rout, just at the moment when the Governor and Vitachuco had finished eating (for the Governor had granted the Cacique all possible courtesies in order to win his friendship), the latter sat bolt upright in his chair and, turning his body from one side to the other, extended his arms in both directions with his hands closed and then brought them back again until his fists rested upon his shoulders. Then he shook his arms once or twice with such force and violence as to cause both bones and joints to crack like breaking canes. The purpose of these gestures was to awaken and call up the force to carry out his plan, and the procedure is a common one which is done almost spontaneously by the Indians of Florida when they wish to accomplish something that requires strength. Having completed these movements, the Cacique rose to his feet with all imaginable savagery and fierceness and in an instant closed with the Adelantado, on whose right he had been seated. Seizing him by the collar with his left hand, he gave him such a blow over the eyes, mouth, and nose with his right fist that he knocked down the chair in which he was seated and stretched him out unconscious on his back as if he had been a child ... Then ten or twelve of them pierced the body of the Indian simultaneously, and he fell dead, blaspheming heaven and earth because he had failed in his wicked attempt ... For the blow which the Governor did receive was so fierce that he was unconscious for more than a half hour, and he bled through the eyes, nose,

mouth, gums, and upper and lower lips as if he had been struck with a large club. Furthermore both his front and back teeth were so tormented that they almost fell out, and for upwards of twenty days he could eat only food that could be taken with a spoon and nothing that had to be chewed.

The demise of the Timucuan and coming of the Seminoles • During the 17th century, the Timucuan Indians were severely decimated by warfare, illnesses including venereal disease, measles, smallpox, and slave raids from Georgia and South Carolina. By 1711, there were virtually none, the last 16 being allegedly packed off on a boat to Europe. During this same period, the Spanish had large cattle ranches in the Alachua savanna area and Spanish missions were prevalent.

The Alachua County region was temporarily void of Indians until 1725 when Creek Indians from Georgia migrated because of British pressure and later runaway slaves penetrated the area and re-established an Indian town, Cuscowilla, between present day Paynes Prairie and Micanopy. By 1750, this mixture of Indians and Blacks had established a new identity—the Seminoles or wild ones. Feral cows and sheep from the defunct Spanish ranches were common along the savanna area now known as Paynes Prairie and the Seminoles became ranchers and farmers.

Bartram's description of the Alachua savanna • William Bartram traveled through the Alachua County region and the Paynes Prairie area in 1774. His account describes the Seminoles in great detail and alludes to several health matters.⁷

The extensive Alachua savanna is a level green plain, above fifteen miles over, fifty miles in circumference, and scarcely a tree or bush of any kind to be seen on it. It is encircled with high, sloping hills, covered with waving forests and fragrant Orange groves, rising from an exuberantly fertile soil. The towering magnolia grandiflora and transcendent Palm, stand conspicuous amongst them. At the same time are seen innumerable droves of cattle; the lordly bull, lowing cow, and sleek capricious heifer. The hills and groves re-echo their cheerful, social voices. Herds of sprightly deer, squadrons of the beautiful fleet Seminole horse, flocks of turkeys, civilized communities of the sonorous watchful crane, mix together, appearing happy and contented in the enjoyment of peace, till disturbed and affrighted by the warrior man. Behold yonder, coming upon them through the darkened groves, sneakingly and unawares, the naked red warrior, invading the Elysian fields and green plains of Alachua.

The Indians abdicated the ancient Alachua town on the borders of the savanna, and built here, calling the new town Cuscowilla: their reasons for removing their habitation were on account of its unhealthiness, occasioned, as they say, by the stench of the putrid fish and reptiles in the summer and autumn, driven on shore by the alligators, and the exhalations from marshes of the savanna, together with the persecutions of the musquitoes.

Bartram also described the great sink from which the Indian name Alachua or "jug without a bottom" is derived.

We alighted in a pleasant vista, turning our horses to graze, while we amused ourselves with exploring the borders of the Great Sink. In this place a group of rocky hills almost surrounds a large bason, which is the general receptacle of the water, draining from every part of the vast savanna by lateral conduits, winding about, and one after another joining the main creek or general conductor, which at length delivers them into this sink; where they descend by slow degrees, through rocky caverns, into the bowels of the earth, whence they are carried by secret subterraneous channels into other receptacles and basons.

Early settlements in Alachua county • Although the first American trained physician who settled in Florida was Dr. James T. Hall, who lived in present day Jacksonville in 1798⁸, Alachua County physicians did not arrive until much later. Alachua County was settled after the Arredondo Grant was awarded to Don Fernando de la Maza Arredondo and his son in 1817. This grant from Spain included 290,000 acres and was contingent on 20 families settling the area.

Florida was then ceded from Spain to the United States on February 22, 1821. After this took place, Horatio Dexter and Edward Wanton as agents for Don Fernando Arredondo nevertheless attempted to settle the Alachua County area in April 1821, in or near the old village of Cuscowilla. Advertisements of the settlement, Wanton, later called Micanopy, were sent as far away as New York and by 1823 some 47 people had come to the area. Among these was a physician, Samuel R. Ayers, appointed for the settlement. Ayers stayed only a few months, however, before departing in May 1823. A Dr. James Kelly of Charleston was then sent to the settlement but little is known of his stay or visits to the area.

In 1824, Alachua County was created but encompassed a very large area east to the St. Johns River, south to near Tampa, west to the Suwannee River and north to the state line. The state census for this large Alachua County was 700 in 1825 but by 1830 was 2200, with some 60 percent being slaves. Towns in Alachua County at that time included Wanton (later Micanopy), Hogtown (later Gainesville), Bowlegstown, Wacahootie, and Dell (later Newnansville). Medicine and disease during this period is described by Palmer in the medical history article published in the Florida Medical Association (FMA) Proceedings⁹.

dians were a strong athletic race, whose superstitious medicine men healed their slight maladies by their unmeaning incantations and the use of some of the many medicinal plants of the country. But when civilization came in, it brought its numerous train of ills that flesh is heir to, and of course brought its remedies and cultivated and educated physicians...

The diseases in the second division of the State were not much developed until after the Indian War, about 1843, as there was very little material for them. As soon after that war as it was safe for immigrants to move in, they came in very rapidly, and soon opened large bodies of rich land for the purpose of planting cotton and other farm products, and, of course, the same experience of the first division had to be gone through with. The malarial diseases prevailed all over the second division to a great extent, until within a few years; intermittent, remittent and congestive fevers were very common; but now, that portion is comparatively healthy, and only subject to these fevers in certain localities—near swamps or prairies which are subject to overflow and then dry up. There are certain conditions of atmosphere also necessary to produce our malarial diseases. Heat and moisture are both necessary, and a certain amount of vegetable matter in a state of decay...

I cannot stop to discuss this prolific subject any farther at this time, but will only say that my observation goes to show that yellow fever can be prevented by strict and proper hygienic regulations, and a strict and perfect quarantine...

Few cases of pulmonary consumption have originated in Florida, and those are among persons so strongly tainted hereditarily that it will take many years' residence here to eradicate the predisposition...

The treatment of our malarial disease is simple and usually successful. An anti-bilious purgative and a few doses of sulphate quinine are all that is necessary. . .

I think that I have shown by statistics that Florida is perhaps the most healthy State in the Union.

In 1828, Newnansville was established as the county seat. This community is well described by Rhett Motte, a surgeon who describes his travels in North Florida during the Seminole War (1836-1837)¹⁰.

Newnansville before this war, could boast of only one block house, eclypt (sic) a court house, and one tavern, built in the same primitive style of architecture. Now it consists of two rival hotels, a fort, shops in abundance, and dwellings, alias shantees, so numerous that for several days after my arrival I could scarcely find my way through the labrynth of streets and lanes, laid out with a pleasing disregard to all rules of uniformity.

This sudden increase of population and consequent prosperity to the incipient city was caused entirely by an innate dread and very natural dislike of its inhabitants to being scalped . . .

The mansions of Newnansville were certainly unique in appearance. Each abode consisted of a shed built of slab-boards enclosing an area about twelve feet square; and were evidently calculated for exercising the rights of hospitality; for the occupants excluded nothing; even the rain always finding ready admittance.

In those days before any large clearings were made, there was no sickness or disease in the country. The In-

Motte also asserts that sickness and disease were by far the greatest enemy of the troops in Florida. Dropsy, typhus, inflammation of the bowels, constipation, diarrhea, congestive fever, yellow fever, and malaria cut through the ranks with relentless fervor. The most common disease was dysentery caused by drinking turbid water from stagnant pools and aggravated by the summer heat.

Alachua County's first physician • The first physician who practiced medicine for an extended period was Dr. George M. Payne of Virginia who moved to Micanopy in about 1843 and purchased land in and around the area. He also served Marion County and at one time was said to have moved briefly to Ocala in 1854. However, census schedules indicate he was a Micanopy resident most of this time as a practicing physician as well as a citrus grower. No date of death for Dr. Payne is known but his name does not appear on the 1860 census¹¹.

Florida's statehood • In 1845 when Florida became the 27th state, Alachua County was still considered a primitive area. The Seminole War was over and many settlers continued to move into the area as new counties were carved away from Alachua, shrinking its size.

Plantations now began to dot the area and cotton, oranges, and other crops were planted as rapidly as the area could be cleared.

It is probably germane to mention that in 1847 while Alachua County was still pioneer country with only one physician, the American Medical Association was created in the northeast United States.

In North Florida, however, pioneer medicine prevailed. Midwives delivered babies and home remedies using local plants were commonly utilized during this period. A listing of some of these home remedies passed down from old Indian remedies to modern times has been previously published and includes: Virginia snake root, a tonic; buttonwood for dropsy (which contains a glucoside); dog fennel for fever, a diaphoretic; poke plant, an indian poultice for skin disorders; black root for abortion, used by the Indians as a powerful purgative; trumpet plant, used by the Indians for smallpox and periwinkle for blood tonic¹².

Early physicians of Alachua County other than Gainesville • *Micanopy*: Although Samuel R. Ayers came to the Micanopy area briefly in 1822 and was replaced by a Dr. Kelly who stayed also briefly, Dr. George M. Payne was the first permanent resident physician (Table I). Other physicians came to this thriving town during the 1850's including Dr. James A. Stewart in 1852; Dr. Frances E. Carn in 1858; Dr. James G. Cameron, Dr. Lewis M. Carn,

Physician (Birth and Death Date)	Med. College	Moved to Area
GAINESVILLE:		
William H. Babcock (1827-1888)	Med. College of S. Carolina	1852
Stephen F. Harvard (1825-1871)	?	1854
Gabriel P. Thomas (1827-1890)	?	1855
William H. Stringfellow (1818-1869)	?	1855
Thomas W. McCaa (1828-1871)	Med. College of S. Carolina	1856
James F. McKinstry (1842-1926)	Long Island Med. College	1866
Robert Y. H. Thomas (1834-1878)	Savannah Med. College	1870
MICANOPY:		
George M. Payne (?-?)	?	1843
James A. Stewart (1823-1871)	?	1852
Frances E. Carn (1823-1860)	Med. College of S. Carolina	1858
James G. Cameron (?-1865)	?	1860
Lewis M. Carn (1838-?)	Jefferson Med. College	1860
Sumter T. Means (1833-1900)	Univ. Penn. School of Med.	1860
Vardy H. Shelton (1830-?)	Med. College of Georgia	1866
Lucius Montgomery (1841-1914)	?	1868
NEWNANSVILLE:		
James G. Dell (1825-1857)	?	1848
Thomas A. Bradford (1830-?)	Jefferson Med. College	1850
Craven Lassiter (1829-?)	?	1853
James A. Williams (1836-1895)	Savannah Med. College	1856
Jerome M. Valentine (1827-1862)	Med. College of S. Carolina	1858
John C. Pelot (1831-1917)	Jefferson Med. College	1858
Thomas P. McHenry (1826-1875)	?	1860
William J. Thomas (?-?)	?	1860
WALDO:		
Vardy H. Shelton (1830-?)	Med. College of Georgia	1856
Oliver P. Hull (1832-1862)	?	1859
Edwin P. Paschall (?-1866)	?	1859

and Dr. Sumter T. Means in 1860. Micanopy was thus served with a total of six physicians immediately prior to the Civil War. Later physicians who came to Micanopy were Dr. Vardy H. Shelton in 1866 and Dr. Lucius Montgomery in 1868.

Newnansville: The first physician who came to Newnansville was Dr. James G. Dell (see Table I) in 1848. He also is likely the second physician who moved to Alachua County. He only practiced until 1854. Dr. Thomas A. Bradford came to Newnansville in 1850 and was also a merchant while Dr. Craven Lassiter came in 1853 and was also a druggist. In 1856, Dr. James A. Williams established practice in this community; he was later to be Captain Dickison's "noble surgeon" and was intimately involved with the Civil War and the skirmishes and battles of North Florida. Dr. John C. Pelot who came in 1858 was another notable physician. Not only was he a practicing physician but he participated in the Secession Convention in Tallahassee in 1861. After joining the Confederate Army in 1862, he never returned to Newnansville

and later settled in Manatee, Florida. Dr. Jerome Valentine also came to Newnansville in 1858 followed by Dr. William J. Thomas and Dr. Thomas P. McHenry who came in 1860. Thus by 1860, Newnansville had a total of seven physicians.

Waldo: Waldo's first physician was Dr. Vardy H. Shelton who established his practice in 1856 but moved to Micanopy in 1866. Later physicians were Dr. Oliver P. Hull and Dr. Edwin P. Paschall both coming in 1859.

The birth of Gainesville • When the decision was made to build the Fernandina-Cedar Key railroad 15 miles south of Newnansville in the area of present day Gainesville, plantation owners in the Hogtown area including Haile, Lewis, and Bailey enticed the State Legislature to pass an act which provided for a county referendum on moving the county seat. A vigorous debate was held at Boulware Springs near Gainesville with the county residents voting to move the county seat to the new town¹³. This took place on September 6, 1854. Major James B. Bailey who owned a plantation on present N.W. 6th Street then sold 64 ¼ acres which would be the downtown area and square for \$242.50. Thus the new town was born.



Figure 2. — Dr. Gabriel P. Thomas - Photo furnished by Dr. W. Thomas Hawkins, his great grandson, a Gainesville physician

Gainesville's first physicians • Merritt^{8,11} suggests Gainesville's first physician arrived in 1855 but other records indicate two physicians arrived earlier than this.

According to E. Ashby Hammond, a noted historian of medical practitioners in Florida¹⁴, the first Gainesville physician was Dr. William H. Babcock (see Table I) who moved to the Gainesville area in 1852 and began practice in 1854 (the town was created that same year). According to his record book now in the P. K. Yonge Library of Florida History at the University of Florida, an entry on February 15, 1854, indicates he was called "for sewing an artery and sewing up a wound for a boy." His record book contains entries from 1854 to 1858 and indicates he treated various fevers, obstetrical cases and trauma. On occasion he used cupping and bleeding and often he used quinine.

Dr. Stephen F. Harvard came to Gainesville in 1854 and not only practiced medicine but was also a farmer and bought and sold real estate.

As the new village of Gainesville grew, three additional physicians arrived from South Carolina during a twelve month period (1855-56).

Dr. Gabriel P. Thomas arrived in 1855 to settle in the downtown area (Figure 2).

Dr. William H. Stringfellow came in 1855 and lived west of Gainesville near an area called Fort Clark. (Figure 3) Dr. Thomas W. McCaa moved to the east area of Gainesville in about 1856. (Figure 4) The three physicians provided additional medical care for the new county seat. In addition, a pharmacist, Steven McCall, settled here about the same time and Dr. James A. Cooper had an apothecary shop in Micanopy.

A typical example of Dr. Thomas McCaa's practice in 1860, when Gainesville had a population of 8,000, involves a ledger sheet from Major James B. Bailey's plantation records now housed in the P. K. Yonge Library at the University of Florida. The visits to the Bailey Plantation were to treat the family of ten plus 34 slaves:

January: Dressings of hand wounds - 5 visits at \$3.00 each

March: Examinations, prescriptions, and directions - 9 visits at \$2.00 each

April: 9 visits at \$2.00 each

June: 1 visit

July: 1 visit

September: 3 visits

October: 2 visits

During the year 1860, Bailey paid a total of \$93.50 for 35 visits.

Civil War medicine in Alachua County • With the onset of the Civil War, Gainesville was depleted of

physicians most of whom joined the Confederate Army. Fortunately, there were few epidemics or adverse health conditions during this period.

Gainesville did experience two confrontations with Federal forces¹³. The first occurred on February 15, 1864, when Federal forces (approximately 50 men plus officers) occupied Gainesville for most of a day and were attacked by 150 Confederate troops. A few men were killed in this skirmish. The second event might more properly be called a battle. This occurred on August 17, 1864. Federal forces consisting of 18 officers and 286 enlisted men led by Col. Andrew T. Harris occupied Gainesville in the early morning and began to plunder the town. Confederate Captain John J. Dickison, who commanded the Company H Second Florida Calvary, engaged the enemy with 175 Rebels routing the enemy with only one killed and five wounded while almost the entire Yankee force was killed or captured except for Col. Harris, the only Union officer to escape.

Richard Taylor, a Lieutenant General in the Confederate Army describes the health conditions of the Confederate forces at Manassas¹⁵. The Alachua County area was probably little different.

In camp our army experienced much suffering and loss of strength. Drawn almost exclusively from rural districts, where families lived isolated, the men were scourged with mumps, whooping-cough, and measles, diseases readily overcome by childhood in urban populations. Measles proved as virulent as smallpox or cholera. Sudden changes of temperature drove the eruption from the surface to the internal organs, and fevers, lung and typhoid, and dysenteries followed. My regiment was fearfully smitten, and I passed days in hospital, nursing the sick and trying to comfort the last moments of many poor lads, dying so far from home and friends.

Medications were obtained from two sources—the Surgeon General of the Confederate States and from local wild plants of medicinal value. A treatise on this subject was compiled in 1863 by Surgeon Francis Peyre Porcher¹⁶, and lists over 400 medicinal plants which could be used by the Confederate Army and civilians as well.

Establishment of the Florida Medical Association and Alachua County Medical Society during the 1870's

● With the beginning of the 1870's, Gainesville had few physicians: Dr. Gabriel P. Thomas and Dr. Thomas W. McCaa both previously mentioned; Dr. R.Y.H. Thomas (brother to Dr. G. P. Thomas), Dr. George A. Penny and Dr. J.H. Verdier, and Dr. James F. McKinstry. Dr. William H. Stringfellow, one of Gainesville's original physicians had died in 1869 and Dr. Thomas W. McCaa died in the yellow fever epidemic of 1871 (see right) and Dr. J. H. Verdier stayed only a short time.

The Florida Medical Association (FMA) was established in Jacksonville in 1874 with Dr. A. S. Baldwin of Jacksonville elected President and 24

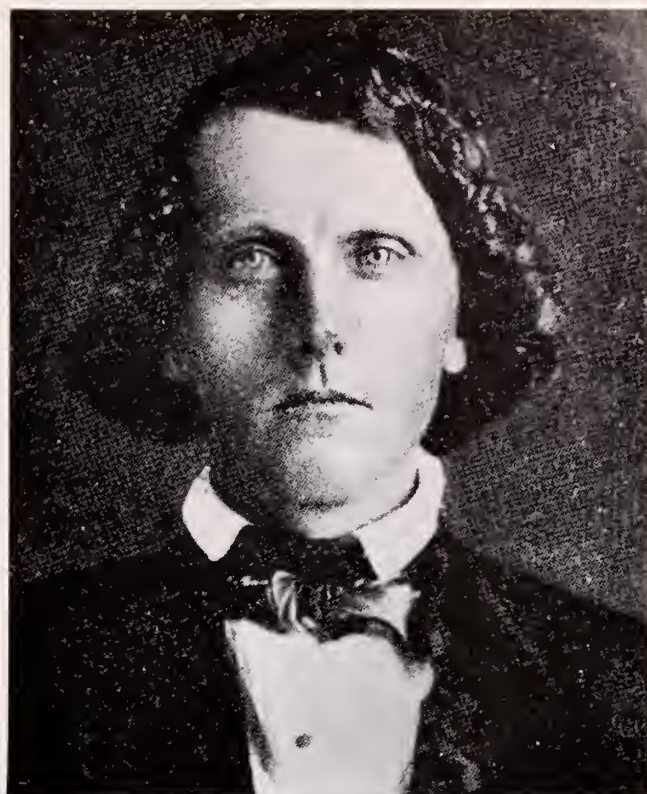


Figure 3. — Dr. William H. Stringfellow - Photo furnished by family members



Figure 4. — Dr. Thomas W. McCaa - Photo from Merritt ¹¹

members from Northern Florida including Tallahassee, Fernandina, Palatka, Jacksonville, and Lake City. No Gainesville physicians joined as charter members but Drs. T. P. McHenry (who died in 1875) and James A. Williams both of Newnansville were Alachua County's representatives during the first meeting. In the 1875 session also held in Jacksonville, Dr. Jim Perry of Alachua was elected to membership in the FMA and a constitution was drafted. Local county societies were encouraged and recommended.

The precise date of the establishment of the Alachua County Medical Society is not known but was sometime between 1874 when the FMA was formed and 1879 when a report in the proceedings of the FMA resolved that "the Association recommend to the various county societies the resolutions of the Alachua County Society for their approval and support"¹⁷. During 1878, N. D. Phillips, a new physician in Gainesville joined and in 1879 Drs. J. G. Bullock of Gainesville and J. Fletcher McKinstry of Gainesville were elected as delegates to the FMA. It is likely that the Alachua County Medical Society was organized in 1877 or 1878 since no allusion to the society is made in 1874, 1875, or 1876 while Alachua County's physicians showed interest, joining and attending sessions in 1878 and 1879.

Alachua County medicine in the 1880's •
Medicine in Alachua County during the early 1880's had changed little from a decade before. Physicians of the area who were FMA members included Dr. J. M. Perry (Alachua), Dr. N. D. Phillips (Gainesville), Dr. J. F. McKinstry (Gainesville), Dr. J. G. Bullock (Gainesville), and by 1885 Dr. T. F. Thomas and Dr. R. A. Lancaster of Gainesville and Dr. W. J. Jolly from Waldo.

By 1885, Presidents of the FMA had come from Jacksonville, Monticello, Key West, Tallahassee, and Pensacola. Dr. N. D. Phillips had been elected Vice-President in 1879 and in 1885 was elected President of the FMA and Alachua County's first to serve in this capacity (Editor's note: For photo and additional information on Dr. Phillips, see page 683). Dr. Phillips' presidential address in 1886 provides insight regarding the concerns of the FMA at this time¹⁸.

I regret to have to state to you, after an investigation made as thoroughly as the daily imperative duties of a regular practice would admit of, that the condition of the medical professions of the State is far from satisfactory. Among the members of the profession, in many sections, there are jealousies, and even unfriendly feelings. There is a want of that harmony and fraternal feeling of good-fellowship that should characterize the conduct, sentiment and disposition of those belonging to the high, noble and ennobling profession of medicine. I find that in a majority of the counties of the State there is no medical society, nor has there been any effort at organization.

If we were but properly organized, first, into County Medical Societies, and each of the county societies sending its quota of delegates annually to the State Association making this body what it should be, an Association large in numbers and powerful in influence, who among you would doubt for a moment the passage of any reasonable bill presented by us to the Legislature. If, gentlemen, we are thus strongly organized, we would no longer be placed in the humiliating attitude of annual unavailing supplicants for recognition at Tallahassee.

It would be a work of supererogation, I am sure, if I should on this occasion, offer any argument intended to prove that Florida should have a State Board of Health. I take it for granted that every intelligent physician in the State is fully alive to the importance of such State Board, yet I will ask, if other States with far less sea coast—and some of them with no sea-coast at all—have found it necessary to create State Boards of Health how much more important it is that Florida, with her borders on three sides exposed and accessible by infected ships from any and every quarter of the globe, should have such a board. Without a State Board of Health, armed with authority and supplied with money, it would be an easy matter for the germs of some deadly contagion to reach our shores and commence their work of devastation at any of the numerous towns dotting our extensive coast.

The object of our Association can be accomplished only by encouraging and demanding a higher standard of education, both literary and medical.

I am glad to see that there is among the advanced thinkers of this country those who have the elevation of the profession most at heart, a growing, strengthening conviction that medical colleges should not have the power of granting degrees with license to practice medicine; that colleges should be restricted to teaching, instructing, educating, and that the licensing power should be vested in a Medical Board or boards entirely independent of any and all medical colleges.

In my opinion a diploma from a Medical College, no matter how reputable such college, should mean no more than that the holder thereof is eligible for examination before an examining board.

On account of defective laws regulating the practice of medicine, Florida has become of late years the resort of a set of the most consummate quacks and unblushing imposters that ever cursed a people, by their dishonest and vicious methods.

If this association has not selected a medical periodical as its official organ, perhaps it would be well for it to do it at this meeting.

Dr. Phillips' comments have a distinct ring of modern concerns of our county associations and the FMA. His concerns and commitment along with other able physicians of the FMA led to the creation of the Florida State Board of Health in 1888 led by Dr. Joseph Y. Porter, a former President of the FMA from Jacksonville.

The FMA met in Gainesville, Florida for the first time in 1888 at the Young Men's Christian Association. By this time, other physicians of Alachua County had joined the FMA including Dr. J. C. Neal of Alachua and Dr. L. J. Burton of Melrose. Dr. Neal delivered a paper on "new indigenous remedies." The delegates were invited and enjoyed a visit to the East Florida Seminary to witness the drill of the cadets. Fevers and epidemics

were discussed at several sessions and six sections of the Society were created including Medicine, Surgery, Gynecology, Pathology, Hygiene and Sanitation, and Diseases of Children. Dr. N. D. Phillips was selected as Chairman of the section on Gynecology.

Alachua County's second President of the FMA, Dr. R. A. Lancaster (see Figure 5), was also elected during this session of 1888.

Dr. Lancaster in his presidential address alludes to the FMA's role in the passage of state laws to regulate the practice of medicine and to establish the State Board of Health¹⁹.

Yellow fever epidemics in Gainesville • The first yellow fever epidemic appeared in Gainesville in 1871 brought from Cedar Key—a total of 50 deaths were reported between September and early December¹¹. It was during this disastrous epidemic that Dr. Thomas W. McCaa died of this malady after attending the victims in Cedar Key.

The second epidemic of 1888 is well described by Dr. J. F. McKinstry (see Figure 6) at the FMA Meeting of 1889²⁰.

On the evening of September 6 twenty-five members of the Gainesville Guards, in vigorous health and free from any shadow of disease, embarked for Fernandina, where they had been ordered for duty by Governor Perry. After five days, on the night of September 11, they returned to Gainesville, having been constantly on duty, ill cared for and seeing much night service. The weather being inclement, some had continuously imbibed the seductive but uncertain corn juice. Of these twenty-five men, five days on duty in Fernandina, two, Evans and Hodges returned with fever, and four Messrs. Wilson, Waugh, Ammons and B. Miller, were unwell. Shiverings, headache, lumbar pains and malaise; all these developed in fever within two days, and one, M. F. Miller, a few days later. Of these Messrs. Evans, Hodges, and B. Miller were seen by me and the remainder by Dr. Phillips. On the 16th these cases, the only ones then under treatment in the city, had so far developed as to warrant a diagnosis of yellow fever. The public announcement through the Board of Health promptly followed and rigorous measures were at once taken to isolate the sick, disinfect premises; and depopulate the city as far as practicable.

The phenomena observed in these cases varying with the stage of the malady was in too wide a range to particularize here. It is usually in the early days we must make our diagnosis. To this end a moderate chill, often nocturnal, a temperature of 101 to 103, usually with pulse disproportionately slow; flushed face, headache, lumbar discomfort, and general malaise markedly out of proportion to febrile movement; a mental apathy sharply in contrast with anxious facial expression, eyes dry and glittering with a peculiar lustre like that of polished porcelain in which light strongly falls, the expression suggesting crippled brain power, a want of ability to concentrate thought and appreciate impressions. Conjunctival vessels are lacking somewhat of the general capillary stasis always present; skin puffy with doughy feel, blood refilling capillary slowly, this most marked on forehead, neck and apex chest; gastric and renal tenderness as shown by deep pressure; alkaline urine.



Figure 5. — Dr. R. A. Lancaster - Furnished by FMA files

These warrant a diagnosis of yellow fever, and with the key of a possible exposure to infection, it may be confidently made without waiting for an autopsy to reveal a possible boxwood liver.

As to treatment in this, as in all self-limited diseases, it should be eminently conservative. Rooms should be well ventilated, preferably by lowering the upper sash, thus guarding against draughts. Covering of bed should be warm but light and frequently changed, as also the personal linen. Abundant nutrition cannot possibly be assimilated, and is not indicated; much harm is unwittingly done by its unwise administration. For this purpose, I prefer a little animal broth, without fat and frequently changed; new beef, new chicken, mutton or game, sometimes clam or oyster—these should be continued far into convalescence. Spongings of the surface, with sedative water, or diluted cologne spirits, is refreshing, cleanses, and disinfects the skin, gives tone to the capillaries and restrains temperature, to which end potent measures are not indicated. Mustard pediluvia are most useful in the first days, but should be restricted to that stage. Brandy is the best stimulant, and in moderate quantities should be used, with a little crushed ice throughout the attack. Light flannels wrung from hot water, rich in mustard, covered with oiled silk, should be applied occasionally over the stomach to relieve engorgement of that important organ, and mitigate nausea. Only in the first hours are purgatives admissible, and salines are to be preferred, as being more prompt in effect, less depressing, and less provocative of nausea. Enemata of glycerine with water will be found to meet the indications, and are innocent of the evils resulting from purgatives. For nausea, a mixture of bismuth, serium oxide, soda bicarb. and cherry laurel, with a trace of morphia, has with me been universally acceptable and generally useful.

Medicine in the 1980's • Dr. R. A. Lancaster of Gainesville who was elected President in 1888 was re-elected President in 1889 for an unprecedented second term.

Dr. Lancaster alluded to Homeopathic medicine and practitioners in his Presidential address²¹:

There is a respectable class of citizens in the State who profess to use only infinitesimal doses and high potencies, or other exclusive lines of practice, and while we cannot receive them into full fraternal fellowship so long as they, by the very name they adopt, continue to proclaim that the true science of medicine is too broad for them, and that they prefer to confine themselves to their narrow dogmas, yet it is proper for the State to take cognizance of this class of citizens; and this could be done by having the three proposed members from the State at large to consist of one Eclectic and two Homeopaths. Just what is meant by Eclectic as applied to a system of medicine at this day and time, I have never been able to ascertain. Still I can see no good reason why the Eclectic should not be recognized as well as the Homeopath since there is probably quite as large a number in the State of the former as of the latter.

He also suggested that the seven Examining Boards which issued licenses to practice in Florida be consolidated into one.

The report of the Alachua County Medical Society during 1890 also addresses the problem of professional relations²².



Figure 6. . Dr. J. Fletcher McKinstry, Sr. - From Merritt ¹¹

We think we have, to a remarkable degree, that feeling of fellowship and good-will for each other which should exist; and almost none of the petty jealousies which too often disgrace the profession when competition is so brisk. From this very fact, we think, our services are more generally appreciated by the public than in communities where the reverse is the case.

Other concerns were expressed during the early 1890's by Alachua County physicians at FMA Meetings including a presentation of mishandled labor cases by midwives, quackery, and illegal practitioners²³.

The law to regulate the practice of medicine has not been rigidly enforced in our county. While most practitioners have complied with the law and obtained certificates from the Board of Examiners, there are some practicing illegally, and it seems to be the duty of no one in particular to see that the law is executed. Some time since, our society appointed a committee to confer with the State Attorney to ascertain from him whose duty it was to prosecute these offenders.

In 1893, Dr. J. Harrison Hodges of Gainesville delivered a scientific address on The Human Brain—an appeal to the General Practitioner to give it more study. This was probably one of the most advanced presentations of a neurological topic presented in Florida up to that time. His colleague, Dr. R. A. Lancaster, also discussed simple continued fevers suggesting treatment should consist of calomel, ipecac, and sodium bicarbonate²⁴. J. N. D. Cloud of Newnansville presented the subject of malarial hematuria with treatment consisting of hot mustard baths, aconite and nitre, sodium bicarbonate, digitalis if congestion developed, arsenic and quinine. He believed quinine caused hemorrhage and "I concluded that I had experimented enough at his expense and commenced to treat him as a sensible man—gave a tonic of strychnine and arsenic and nutritious food and he made a rapid recover"²⁴.

The FMA met in Gainesville on April 16, 1895, and Dr. J. Harrison Hodges once again delivered the annual oration, this time on "The Physician and the Advance of Medicine as a Science"²⁵.

The high code of honor under which the physician works makes him present rather an anomaly; one which is unique and unknown to any other class of workers, inasmuch as, while he earns the sustenance necessary for life by ministering to the sick, he spends his existence in an effort to prevent the spread of disease. Better health, greater happiness and length of days for all humanity is what he industriously labors to accomplish.



Figure 7. — Dr. J. Harrison Hodges - Furnished by FMA files

The kind of surgery and the conditions under which it was performed by the surgeons of Alachua County in 1896 are described by Dr. J.N.D. Cloud²⁶.

On November 4, at five o'clock in the morning, Cyrus Grant (negro), 30 years of age, was shot with a 38-calibre Smith & Wesson pistol at a distance of ten or fifteen paces, the ball entering on left side, just above the anterior superior spinus process of the ilium. The ball took rather a transverse direction. The patient was carried a mile and a half in a rough wagon, four and a half hours after the shooting took place. At 10 a.m., my brother, Dr. J. L. Cloud, and I were summoned to his bedside. He was in a dirty filthy, negro cabin, with the most unfavorable surroundings for an operation, especially of such magnitude. We arranged two small tables upon which the patient was placed and thoroughly scrubbed with hot water, after which the anesthetic was given by my friend, Dr. Walts, while we prepared the instruments, which consisted of bistouries, retractors, artery forceps, scissors, and needles, in carbolized water. The incision was made in the median line, beginning about an inch and a half below the umbilicus. After the opening was made it revealed very conclusively that hemorrhage had been going on very extensively from the amount in the cavity. The bowels were drawn out and thoroughly examined, which disclosed twenty-one (21) perforations, besides several different perforations and contusions of the meso-colon. The margins of the wounds were pared and turned until healthy serious tissue was brought in close apposition, and fine silk sutures put in. While operating, hemorrhage made his appearance from three branches of the inferior mesenteric artery, which was immediately controlled with silk ligatures. Having completed the intra-abdominal work,

that is, the suturing and ligating, the cavity and bowels were flushed several times with hot carbolized water, after which the bowels were carefully replaced, the external incision being closed with silk sutures, consisting of two sets, deep and superficial, the deep entering through the integument, fascia, muscle and peritoneum, the superficial through the integument and fascia. The dressing consisted simply of turpentine and absorbent cotton, with a bandage about eight inches in width around the abdomen.

Unfortunately on the tenth day he abruptly expired.

By 1898, 44 physicians practiced within Alachua County (see Table II). Of these, 13 were from Gainesville and 16 were FMA members.

TABLE II
Alachua County Physicians 1898

Barry, N. J.	Yular
Bingham, R.	Melrose
Burnham, N. S.	Melrose
Cloud, J. L.	Alachua*
Cloud, J. N. D.	Newnansville*
Cloud, R. A.	High Springs
Clyatt, E. L.	LaCrosse*
Colsom, J. H.	Waldo*
Curtis, John B.	Orange Heights*
De Pais, Jas	Archer*
Flake, Wm.	Gainesville
Giddins, S. B.	Gainesville
Hodges, B. C.	High Springs
Hodges, J. H.	Gainesville*
Howell, E. B.	Newberry*
Hunter, T. C.	Hague
Johnson, W. C.	Micanopy*
Johnson, W. W.	Hawthorne
King, J. W. F.	Gainesville
Kelly, J. L.	Windsor
Lancaster, R. A.	Gainesville*
Lartigue, Dr. Etienne	Gainesville*
Lester, J. H.	Rochelle
Mathews, A. H.	Micanopy
McKinstry, J. F., Sr	Gainesville*
McKinstry, J. F., Jr	Gainesville*
McLeod, Thomas	Newberry
McRae, F.	Melrose
Montgomery, L.	Micanopy*
Parker, J. H. (col.)	Gainesville
Phillips, N. D.	Gainesville*
Price, Z. M.	Micanopy
Rainey, N. J.	Yular
Robb, Mrs. S. L.	Gainesville
Robb, R. L.	Gainesville
Rodman, B. C.	Osceola
Rush, Chas.	High Springs
Southerland, W. R.	High Springs*
Strickland, G. W.	Waldo
Tanner, G. W.	Lexington
Thomas, T. F.	Gainesville*
Watts, J. W.	LaCrosse
Wheateley, -	Osceola
Vanlandingham, B. F.	Campville

*FMA Members

Dr. J. Harrison Hodges was elected President of the FMA in 1899 (see figure 8), Gainesville's third FMA President, a fitting way for Alachua County to enter the twentieth century with an adequate number of physicians and reasonably represented in the FMA.

Conclusion • Alachua County, like many Florida counties, has a rich tradition in history in general and medical history in particular. Beginning with the Timucuan Indians living around the beautiful Paynes Praire, these times were followed by the building of the Spanish missions and cattle ranches. The demise of the Timucuan and re-settlement by the Creek Indians and run-away slaves, later to be called Seminoles was followed by the pioneer settlers, the acquisition of Florida by the United States, and finally by the establishment of Alachua County. After this period, physicians began to move into various towns to practice medicine.

Many other Florida counties have fascinating and intriguing histories. It is hoped that each County Society will appoint medical historians and compile and publish this record for all of the FMA members.

Acknowledgement

Dr. E. Ashby Hammond is Professor Emeritus of History at the University of Florida and graciously furnished much information on Alachua County physicians. He is preparing a Register of the early Florida physicians to be published in the near future.

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• Dr. Barrow, 1130 N.W. 64th Terrace, Gainesville 32605.

The Robb House

Home of the Alachua County Medical Society and Auxiliary

The Robb House Committee:

Dr. Mark V. and Mary B. Barrow; Mrs. Marion Gilliland; Dr. W. Thomas and Mary Lou Hawkins; Dr. D. Orvin and Cathy Jenkins; Dr. Walter H. and Jean Marshall and Mrs. Florence Van Arnam.

The Robb House in Gainesville is now the home of the Alachua County Medical Society and Auxiliary.

This Victorian cottage was constructed before 1880, probably about 1878, by Joseph H. Avera, a blacksmith. The original street name was East Liberty Street, but this was later changed to East University Avenue.

In 1882, at age 42, Robert Lee Robb, M.D., a homeopathic physician, came to Gainesville from Chicago, Illinois, in hope of recuperating from tuberculosis. Dr. Robb was born in 1840 in Iowa where his family owned a furniture business. He graduated from Missouri Homeopathic College of Medicine in 1873.

His wife, Sarah Lucretia Robb, M.D., three daughters and a son joined him in Gainesville in 1883, after he had fully recuperated from the tuberculosis. Dr. Lucretia Robb had obtained an R.N. degree at Hahnemann Medical College in Philadelphia. Her husband, whom she married on February 14, 1872, recognized her potential abilities as a doctor and, since she was refused entry by U.S. medical schools, he traveled with her to Germany where after two years of study, she received her M.D. degree in Heidelberg. Prior to coming to Florida, they lived in Chicago.

After moving to Gainesville as one of Florida's first husband-wife physician teams, they initially resided at 916 N.E. 3rd Avenue in a beautiful Italianate Victorian home built by Dr. W.L. Siegler.

In 1882, the Robbs, with another physician, published their book, *The Robb's Family Physician*, a book of common sense medicine to be used by the public.



The Robb House, home of the Alachua County Medical Society and Auxiliary. (Photo by O. Frank Agee, M.D.)

The Authors

THE ROBB HOUSE COMMITTEE:

Dr. Mark V. Barrow, chairman of the Robb House Committee, practices internal medicine and cardiology in Gainesville. Other committee members are: Mary B. Barrow, Mrs. Marion Gilliland, Dr. W. Thomas and Mary Lou Hawkins; Dr. D. Orvin and Cathy Jenkins; Dr. Walter H. and Jean Marshall and Mrs. Florence Van Arnam.

Initial purchase of the house • In 1898, the Robbs purchased Joseph Avera's house for \$1,000 and a year later added a southwest office addition resulting in two unique bays — one triangular in shape on the east side and one square in shape on the west. There the two physicians continued their medical practice.

Dr. Robert L. Robb, an entrepreneur, was instrumental in establishing the Oddfellow's Home in Gainesville. Earlier he had been deeply involved in the development of a suburb and a health spa for the Gainesville area. A street railway system to the area from downtown Gainesville was planned, however the yellow fever epidemic in Gainesville during 1888 thwarted this dream. In addition, Dr. Robb owned and operated a furniture factory located in east Gainesville. Together the two physicians operated one of the first private boarding schools in Alachua County and Dr. Robert Robb later served on the county school board. His health failed and he died in 1903 at the age of 62.

Dr. Sarah Lucretia Robb continued to practice in her home and office. She was literally a "horse and buggy doctor" who traveled widely throughout Alachua County administering to the sick and delivering babies. In addition she had a busy practice at her home/office where she also had a two bed clinic which could be used for overnight patients. Dr. Sarah Robb practiced until 1917 when she retired. In retirement she continued to be an active citizen and member of the Presbyterian Church until her death on May 3, 1937, at age 84.

During her later years, Dr. Robb had taken in a boarder who became her confidante and constant companion. Margaret H. Gross (known affectionately as Grossie) had set out from Canada with her son who was quite ill, in the hope that he would regain his health. However he died in Georgia enroute to Florida.

Fate of the house in later years • At Dr. Sarah Robb's death, the Robb house was willed to Margaret Gross. On October 28, 1938, Mrs. Gross gave the house back to Dr. Robb's three daughters. In December 1939, the three sisters sold the house to an attorney, Joe C. Jenkins, Sr., for \$2,884, and in October 1973, his son sold the house to another group of attorneys represented by Henry L. Gray. The house was used for a long period of time as a dance studio and later a karate training center with small apartments in the rear. After several years it fell into complete disrepair.

It was scheduled for demolition by the city when the Alachua County Medical Society became interested in the house as its future office. The lot on which it stood was felt to be too expensive for a purchase on site, therefore the Society purchased from the City of Gainesville a lot some twelve blocks away at 235 S.W. 2nd Avenue. The Robb house was then purchased from the group of attorneys for one dollar. On April 11, 1981, the house was moved intact to the new site and restoration was begun. This was completed some nine months later at an approximate cost of \$90,000. Professor F. Blair Reeves, Phillip P. Wisley and a group of students in preservation architecture at the University of Florida prepared a complete historical assay and full feasibility study which were very helpful during the restoration process. Several family members provided photographs and background information so that the restoration could be as authentic and complete as possible.

The formal dedication for the Robb House was held on April 17, 1982, and at that time Henry J. Babers Jr., M.D., who served as President of the Florida Medical Association in 1969, delivered the dedication address. Dr. Babers concluded his dedicatory remarks expressing his wish that, "this house should remind all physicians what the past was like locally, how the physicians coped with difficult conditions in the past and how different some of our problems are today. Hopefully we can use this house with a sense of history and can remember to be proud and humble at the same time."

An early physicians' home and office in Alachua County, the Robb House stands as a monument both to the early physicians of Alachua County and to the 450 present day physicians of Alachua County. In addition to housing the offices of the Medical Society and Auxiliary, the Robb House will be used for historical and instructional medical and health exhibits.

- Dr. Stewart, 3661 South Miami Avenue, Miami 33133.

Dr. Newton D. Phillips,

Florida Medical Association's Eleventh President

E. Ashby Hammond, Ph.D.

Among the most beloved and highly respected physicians to practice in Alachua County, Florida, in the nineteenth century was Dr. Newton D. Phillips. Upon his death on October 5, 1909, a friend and former patient wrote:¹

Who to the manor born can forget the elegant and stately figure of Dr. Phillips as he ministered day and night, in and out of season, to rich and poor alike, with equal benignity, skill and devotion?...When his noble presence was felt in the sick room the battle was half won...I shall always remember his visits to me...I can see him now, tall as a poplar, straight as an Indian, yet graceful in his movements to a marked degree. His presence beamed with a sweet majesty seldom seen among men, and impressed upon the manhood of his section as ideal pure and strong...How can old Alachua repay the debt she owes to Alabama for the loan of him?

Newton Dekalb Phillips was born in what would later become Clarke County, Mississippi, on May 20, 1835. His father, Thomas (possibly Thomson) Phillips,² a North Carolina native, and his mother, Lydia Scales, a South Carolinian, were married about 1830 and moved to Mississippi a short time later. The land in eastern Mississippi being relatively cheap at the time they were able to acquire fair acreage and settle down to the life of middle class farmers. Within a year after Newton's birth, however, his father died, leaving his widow with four small children.³

Educational background • In spite of the hardships facing Mrs. Phillips she was able to provide young Newton with such education as the little town

of Shoeboota (later known as Shubuta), near which their farm lay, had to offer. Upon arriving at adolescence he was able to attend a "larger school then well-known in Eastern Mississippi,"⁴ where he apparently absorbed the elements of a classical education, and where he developed an interest in medicine.

It is not known whether Phillips had the advantage of a local medical preceptor but it is quite



Dr. N.D. Phillips — Furnished by FMA files.

The Author

E. ASHBY HAMMOND, PH.D.

Dr. Hammond is Professor of History, Emeritus, University of Florida; and has been a past contributor to the historical issues of the Journal.

likely that he did. At the age of 23, somewhat beyond the age of most beginning medical students, he enrolled in the University of Louisville's Department of Medicine in the fall of 1858, just at a time when the quality of medical education in Louisville had deteriorated. A bitter rivalry was being waged between the University's School of Medicine and the Kentucky School of Medicine, also in Louisville.⁵ It was probably for that reason that young Phillips transferred in the fall of 1859 to the Jefferson Medical College in Philadelphia, where in the following spring he was graduated Doctor of Medicine.⁶

Fortunately, two letters of this period written by Dr. Phillips to his brother Jasper, have survived;⁷ the first penned shortly after his arrival in Philadelphia, the second on January 27, 1860. The first recounts the long journey from Mississippi to Philadelphia, revealing his interest in the passing scenes, rural as well as urban.

The greater portion of the country through which I passed was replete with the most beautiful scenery. That portion of East Tenn. and West Virginia through which the railroad passes was certainly the most beautiful I ever beheld. The rapid succession of mountains, hills, valleys and rivers, vilages (sic), cedar forests and tobacco plantations was so attractive and interesting to me that I was sorry to see night come.

A greater enthusiasm, however, was reserved for Washington, where he loitered for a day. Phillips and three of his travelling companions hired a cabman to show them the places of greatest interest in the city. Near the White House they enjoyed the pleasant surprise of seeing President Buchanan on his morning walk. As Phillips related it:

Just as we drove up "Old Buck," as he is often called, was walking. He passed within a few yards of us, but not being satisfied with the view we got of him we made the cabman drive around a square and stop until he passed a second time. He passed very close to us that time and, I think, recognized us as the same persons whom he had just seen at his house. He looked at us very inquiringly and gave us a slight but very polite bow of his snow-white head.

From the White House they went to the Washington Monument, still far from completed. Phillips remarked upon numerous marble slabs, with inscriptions upon them, gifts of foreign governments, but yet to be inserted into the monument.

Continuing northward on the following morning Phillips got only a passing view of Baltimore, but declared it "a very pretty city." Philadelphia he found most agreeable. "I don't think," he wrote, "I ever saw a more courteous and accomodating people. I don't suppose they know as much about disinterested friendship as our southern people do, but they know all about the rules of politeness and courtesy. As for slaves, I hardly ever hear it mentioned."

Phillips' second letter expresses his anxiety concerning the upcoming thesis preparation and

final examinations. He was spending, he said, two to three hours per day in the quiz room, in what would today probably be called review or "cram" sessions. He confessed, "I occasionally have a slight attack of palpitation, resulting from thinking of that final ordeal through which we are compelled to pass." But he added, "I am in hopes, however, that I shall come through safely."

Phillips wrote with much admiration and respect for several of his professors and lecturers, "Meigs, Dunglison, Bache, Pancoast, and Gross..."⁸ truly great men...names familiar not only to the medical profession, but also to the literary portion of the community generally." His letter ended on a not unfamiliar note: Would his brother be so kind as to borrow \$50 for him as he was very short of funds. It scarcely requires emphasizing that these letters, as well as three others, reveal a man of exceptional sensitivity, perceptive intellect and nobility of character.

Medical service for the Confederacy • After the exhilaration of Philadelphia and the challenge of the Jefferson experience, it must have been a letdown to return to rural Mississippi. But return he did, not to Shubuta, but to Quitman, the Clarke County seat, where he began his practice.⁹ The War was drawing nigh, however, and on April 24, 1861, he enlisted in the Army of the Confederacy, was mustered in two months later by General Benjamin F. Cheatham himself, and assigned to Capt. James S. Terrell's Company of Chickasaw Guards ("Chickashay Desperadoes").¹⁰ Rerick states that for an unspecified period he was contract surgeon for the battery of General Martin L. Smith, who was in charge of building the defense for the city of Vicksburg. About midway of the War he was promoted to a first lieutenantcy and assigned as assistant surgeon to General Cheatham's Division. In this capacity he was present at the battle of Atlanta in the summer of 1864.¹¹

The last weeks of 1864 found Dr. Phillips "In the Field, near Florence, Alabama." His letter of November 20, 1864, to his mother, obviously calculated to reassure her as to his safety, dealt with trivia such as the difficulty in locating proper buttons for his uniform, the poor quality of food, and the importance of obtaining a new suit to wear home. Still the weariness and fatigue of war showed through. He ended with the information that his unit would be moving into Tennessee on the following morning; certainly not cheerful news.

Upon his release from the Army, precise date unknown, Dr. Phillips returned to Shubuta and resumed his medical practice. It was only a matter of weeks, however, before he removed to Alabama, settling in the town of Tallassee, some thirty-five miles northeast of Montgomery where he resumed his practice and where, on February 17, 1869, he was married to Kate Jordan, a girl of seventeen, who possessed the most admirable qualities.¹²

The move to Gainesville • In early 1876 he moved to Gainesville, Florida, where he was destined to spend the rest of his professional life. The reasons for the move remain obscure, but it seems a reasonable assumption that he was seeking a more lucrative practice than that afforded by depression-ridden Alabama. By this date three daughters had been born to the Doctor and his wife: Katherine, Willie Mary, and Ruby Lyola. A fourth daughter, Clara Nell, was born in Gainesville in 1880.¹³ Due to his straitened circumstances Mrs. Phillips and the children were left in Tallassee until such time as he could make arrangements for them to join him.

Those early weeks in Gainesville were a dreary time for Dr. Phillips. A minor illness combined with the uncertainty of his future produced a state of depression. On March 8th he received two letters from his wife, adding unbearable homesickness to his woes. He dared not reply immediately, but on the following day he wrote:

My inclination was to sit down and reply at once...but I would not trust myself...I was *too blue*, so much so — shall I acknowledge the weakness? — that in spite of all my efforts...the tears flowed freely. I really felt that if it were not for you and the little ones, life would have little attraction for me, and that it would be agreeable to pass off into the long sleep. But I feel much better this morning, both physically and mentally...But how can I get along without you and the babies? If I only had the means to bring you all down here I would feel like a new man. And my chances for building up a practice would be better.¹⁴

Phillips then spoke of the possibility of joining Dr. L. Preston Ashmead, a tubercular patient recently arrived in Gainesville with the hope of regaining his health. As for such a prospect he wrote, "I am inclined to think it would answer very well, for his being from the North will get us a good deal of the northern invalid practice." The partnership materialized and proved to be a most compatible one, only to be terminated by the untimely but not unexpected death of Dr. Ashmead on March 12, 1878.¹⁵

Thus was Dr. Phillips' Florida career launched. Meanwhile he had bought a fine mare, a buggy with accessories,¹⁶ and in due time was able to bring his family from Alabama. Life took on new meaning for him as he gained the trust and affection of the people of Alachua County and beyond. In October 1878, the local newspaper noted: "Dr. Phillips was summoned twice during the past week to attend a serious case in Cedar Keys."¹⁷ His practice encompassed the common ailments — fevers, alimentary disorders, post-mortem examinations, and not infrequently, the bloody results of crimes of passion.

Leadership roles • Dr. Phillips' qualities of leadership soon became apparent to the medical faculty of the area. He assumed an influential role in the Alachua

County Medical Society, being elected its president in 1893.¹⁸ With his increasing popularity came a degree of financial success. The Gainesville newspaper from time to time took note of his success. In June 1877, it announced that the Doctor "has moved into the neat, elegantly-furnished dwelling lately built by Dr. William H. Bracey" dentist.¹⁹ Six months later it informed the public that he had purchased "the Finley place, situated in front of Dr. McMillan's and will commence improvement at once with a view to residing there."²⁰ Three months later he removed his office "into the building formerly occupied by the Telegraph Company, opposite the Arlington House... where he has fixed up quite a neat office."²¹ On June 19, 1885, the Gainesville *Alachua Advocate* stated: "If you want to see the most cozy office in the City, call on Dr. N.D. Phillips in his new quarters in Dr. (Watson) Porter's new 'office block'." Before the end of the century Dr. Phillips had purchased a desirable home located at 301 East Main Street, North (now 203 N.E. 1st Street, where the law offices of Dell, Graham, et al. now stand).

The inadequate professional training of many of Florida's physicians as well as the generally low quality of medical practice in the State were matters of deep concern to Dr. Phillips. The chief hope of improving the situation, in his opinion, lay first in organizing the physicians into county medical societies, and subsequently into a strong statewide organization, capable of rooting out the unqualified and promoting regulatory legislation at the state level. Thus motivated, he made his first appearance at the annual meeting of the Florida Medical Association in Jacksonville in April 1878. At the morning session of the third day, as a discussion on the origin of yellow fever was in progress (with Drs. Abel S. Baldwin of Jacksonville and R.D. Murray of Key West arguing for their respective theories), Dr. C.W. Horsey of Fernandina arose "to a question of privilege, and it being granted, he introduced Dr. N.D. Phillips, of Gainesville, Florida, and nominated him as a permanent member of the Association, which nomination was approved."²²

Dr. Phillips proved to be a valuable member. Before the 1878 sessions were finished he was appointed to a committee charged with drafting a revision or a substitute of the laws governing the practice of medicine in Florida. In the following year he was elected second vice president of the Association, and in 1885 at the Sanford meeting he was chosen as its president.²³ In 1886 the group met in Palatka, where, in his presidential address, he aired his convictions. After a self-effacing statement of regret that the responsibility for his remarks "had not fallen to an abler mind...one trained in the art of discussion," he proceeded in a clear and straightforward manner to express his concerns. He lamented the failure of physicians in several counties to organize medical societies, stating

that such organizations were the only agencies capable of dispelling the legislative hostility toward the medical profession and of obtaining constructive medical legislation at the State level. He then urged the formation of a State Board of Health and a viable Medical Examining Board, convinced as he was that a mere diploma from a medical school should not be the sole basis for obtaining a license to practice.²⁴

His most deadly dart he aimed at Florida's lax laws, "which have resulted in the State's becoming the resort of a set of the most consummate quacks and unblushing imposters that ever cursed a people by their dishonest and vicious methods." He concluded with an exhortation to his colleagues to join in the struggle to elevate the profession. It was an impressive speech.

In subsequent years Dr. Phillips attended only the meetings of the Association held in towns conveniently situated to Gainesville, e.g. Gainesville in 1888, Ocala in 1890, where as chairman of the Section on Gynecology he read a scholarly paper on the subject, reviewing its history from Hippocrates through the long interval when obstetrics was the exclusive province of midwives, on into the nineteenth century when, through the work of Recamier of France, J. Marion Sims of the United States, and others, it was returned to the purview of the physician. Dr. Phillips retained his membership in the Association until his death, last attending the session of 1906 in Gainesville.²⁵

In the civic and religious life of Gainesville, Dr. Phillips was equally active. He was a devout parishioner of Trinity Episcopal Church (later to be called Holy Trinity). In 1879 he was elected to the vestry and some years later served as junior warden. When the present church building was begun in 1905 both Dr. Phillips and his wife contributed substantially to the building fund. Mrs. Phillips donated the pulpit and the clergy stall with prie-dieu (praying stool).²⁶ The Phillips' daughters also aided in the growth and ultimate success of the Church, the eldest daughter, Kate serving as the first director of St. Mary's Guild (1890), an office assumed in 1893 by her sister, Willie.²⁷

Although he maintained a cheerful demeanor throughout much of his later life, he was destined to endure much sorrow. From time to time he suffered through periods of poor health which on some occasions necessitated his suspending practice. More devastating, however, were the untimely deaths of two of his daughters, Willie, the wife of Frank Milstead, who died in 1899, and Ruby, wife of David W. Travis of Jacksonville, who died in 1908. By comparison, the complete destruction of his fine orange grove on Lake Wauberg in the great freeze of January 1886, was a minor matter.²⁸

The last years of his life Dr. Phillips and his wife spent with their daughter, Mrs. Travis, at 735 Charles Street in Jacksonville. Upon his death at the age of

74 his body was returned to Gainesville for a funeral service at Holy Trinity, an occasion which was solemnly observed by the business and professional community who closed their shops and offices out of respect. The local newspaper reported a "very large attendance, largest in Gainesville in some time, which shows the mark of love in which the deceased was held by the citizens of his old town." He was buried in Evergreen Cemetery.²⁹

Footnotes and References

1. Jacksonville *Florida Times Union*, Oct. 6, 1909.
2. Rowland H. Rerick, *Memoirs of Florida* (Atlanta, 1902), II, 654-5. This biographical sketch was prepared at the time Dr. Phillips was at the height of his career, and has been accepted as basically accurate. The name Thomson appears in the Rerick sketch. However, Dr. Phillips' granddaughter, quoted by her son, Dr. Breckinridge W. Wing of Orlando (correspondence with Dr. William M. Straight 1/23/68), states Dr. Phillips father's name as Thomas and gives his birth date as May 30, 1835. She gives his birthplace as Hims County, North Carolina. She states that sometime after Dr. Phillips' birth the family moved to Mississippi.
3. U.S. Census Office, Sixth Census (1840), Clarke Co., Miss., p. 129. The Slave Schedule of that year indicates that Mrs. Phillips owned eight slaves. In the letters of Dr. Phillips he mentions only one sibling, namely his brother Jasper, two years his senior. Two daughters are indicated in the 1840 Census, however.
4. Rerick, *Memoirs*, loc. cit.
5. John H. Ellis, *Medicine in Kentucky* (Lexington, 1977), pp. 16-17.
6. Jefferson Medical College, Philadelphia, "List of Dead or Lost Graduates in Classes from 1826 to 1879." Provided, courtesy of the Librarian, Scott Memorial Library, Thomas Jefferson University, Philadelphia.
7. A total of five letters of Dr. Phillips' have survived. The author has obtained photo copies of these. Two were addressed to his brother, two to his mother, and one to his wife. The originals were given to the Florida Medical Association by Dr. B.W. Wing, great grandson of Dr. Phillips.
8. These physicians, all men of distinction, were among the notables of mid-nineteenth-century American medicine. Charles D. Meigs, Professor of Obstetrics at Jefferson, was well-known for his book, *Females and Their Diseases* (1849); Robley Dunglison, known for his medical dictionary and numerous textbooks on various branches of medicine; Franklin Bache, remembered for his contributions to the widely-used *Dispensatory of the United States* (1833); Joseph Pancoast, famous for having performed the first successful operation for exstrophy of the bladder (Feb. 1858); and Samuel David Gross, Professor of Surgery at Jefferson, 1856-82, considered by many to have been the greatest surgeon of his time. See Fielding H. Garrison, *An Introduction to the History of Medicine*, 4th ed. (Philadelphia, 1929), p. 599.
9. U.S. Census Office, Eighth Census (1860), Clarke Co., Miss., p. 113. It is here shown that Dr. Phillips, aged 25, and owner of property valued at \$1850, was sharing a house near Quitman with his friend, Charles W. Barnett, farmer, aged 22, whose property was valued at \$28,625. In Phillips' letter of Nov. 26, 1864, to his mother, "Charlie" Barnett was said to have been home on leave and Phillips was requesting that his mother send certain things to him "by Charlie," who had just been elected to a lieutenantancy.

10. Information from General Services Administration, Washington, is in some instances not in agreement with the Rerick account.
 11. Letter, Phillips to his mother, dated August 13, 1864, "In the Field, Cheatham's Division Hospital."
 12. Information, courtesy of Dr. William M. Straight, Miami, Fl.
 13. The author gratefully acknowledges the following information provided by Mrs. Wm. E. Roberts, Gainesville, Fl., great-niece of Dr. Phillips. The eldest Phillips daughter, Kate, was married (1) to John A. Ammons, and (2) to C. Breckenridge Wilmer of Atlanta. Willie Mary, the second daughter became the wife of Frank Davis Milstead of Gainesville, while the third daughter, Ruby Lyola, was married to David W. Travis of Jacksonville. The youngest daughter, Clara Nell, was married to Lemuel Roberts Woods of Tampa. At least one child was born to each of the Phillips daughters, but no effort has been made in this study to identify the Doctor's grandchildren and great-grandchildren. It is stated in the obituary notice of Mrs. Phillips that she had nine grandchildren, all of whose names are listed. See Gainesville *Daily Sun*, July 21, 1932.
 14. Letter, Dr. Phillips to his wife, Mar. 9, 1876.
 15. Gainesville *Times*, Mar. 13, 1878.
 16. See note 14, *supra*.
 17. Gainesville *Times* Oct. 23, 1878.
 18. Gainesville *Sun*, Feb. 9, 1893.
 19. Gainesville, *Times*, June 2, 1877.
 20. *Ibid.*, Jan. 26, 1878.
 21. *Ibid.*, Sept. 8, 1877. The telegraph office was apparently located on Garden Street (now SW 1st St., between 3rd and 4th Avenues), just west of the Arlington House, Gainesville's best hotel. If so, it would have been an ideal place for treating invalids wintering at the Arlington.
 22. Proceedings, Florida Medical Association, Sess., 1878 (Jacksonville, 1878), pp. 17, 19.
 23. *Ibid.*, Sess., 1885 (Jacksonville, 1885), p. 11. At the 1883 session Dr. Phillips had been elected first vice president for the ensuing year.
 24. *Ibid.*, Sess., 1886 (Jacksonville, 1886), pp. 12-19.
 25. *Ibid.*, Sess., 1906 (Jacksonville, 1906).
 26. Benjamin P. Richards, "History of Holy Trinity Episcopal Church" (Gainesville, Fl.), Unpubl. Ms., typed copy, P.K. Yonge Library of Florida History, University of Florida, Gainesville, p. 183.
 27. *Ibid.*, pp. 119, 121.
 28. See note 1, *supra*.
 29. Gainesville *Daily Sun*, Oct. 7, 1909. Mrs. Phillips lived until July 20, 1932, and died at the home of her sister, Mrs. W.W. Hampton. She was buried beside her husband in Evergreen Cemetery, Gainesville.
- Dr. Hammond, 404 Library West, University of Florida, Gainesville 32611.

Patient letters to an early nineteenth century Virginia physician

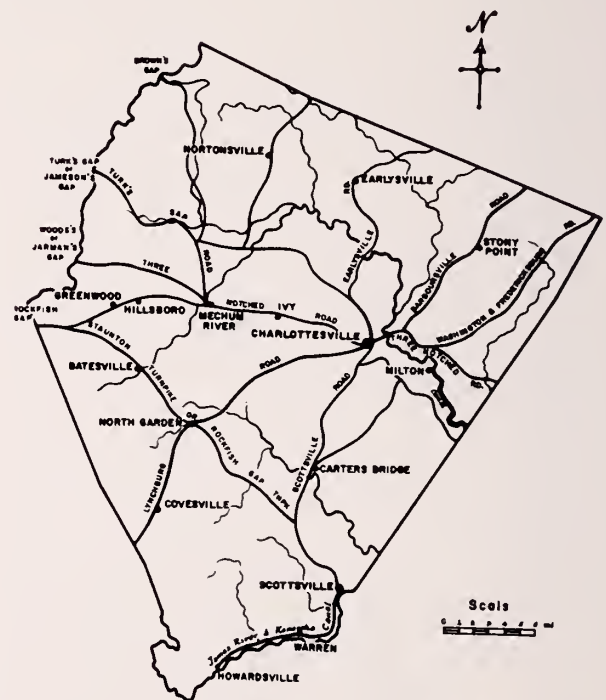
Todd L. Savitt, Ph.D.

When sickness or injury occurs in a modern household the usual first response is to treat the problem with known home or over-the-counter remedies. Only if self-dosing by friends and family fails do individuals then turn to professional health care providers, generally to physicians. The amount of home treatment given and the point at which physicians are consulted differs depending upon the education, income, age, sex, race, region, and cultural background of the patient and the household.

As the following letters will attest, the health behavior of rural early nineteenth-century Virginians was remarkably similar to that of modern day Americans. They used their own knowledge and experience first, and called in the physician if the patient declined or remained unchanged. Though medical science was not as advanced as it is today, physicians had the trust of their patients for most medical problems. However, because of their isolation and their poor accessibility to physicians, rural folk in general tended to rely longer than town and city dwellers on their own time-tested approaches to illness and injury before consulting a professional.

Healers usually treated the sick at their homes. But, as the correspondence here indicates, they also had to provide advice and medicine to people who sent letters or messages describing symptoms and

events in the course of an illness. Some who wrote even went so far as to ask for the loan of instruments so they could treat themselves. Time was always a factor, since as much as a day might elapse before the physician could appear or reply in writing. Calls for help and visits or replies of medical advice travelled only as fast as horses' or humans' legs.



ROADS & CANALS, 1850

Fig. 1. — Map of Albemarle County, Virginia, 1850. (Source: John Hammond Moore, *Albemarle, Jefferson's County, 1727-1976* [Charlottesville, 1976] p. 178).

The Author

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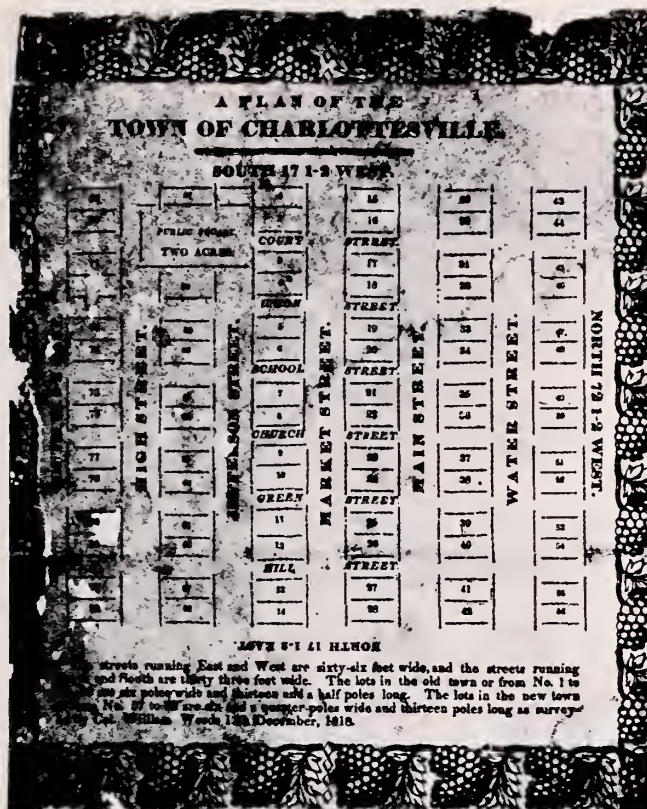


Fig. 2. — Plan of the town of Charlottesville, 1818. (Source: Moore, Albemarle, Jefferson's County, p. 101).

In addition to caring for the sick, physicians played an important social role in the community. Because they were so mobile, they passed many homes and farms and saw a number of people each day. Physicians in rural areas carried local news and, when asked, served as messengers and communication links for the sick or invalid.

The letters reproduced below, from white owners of ailing slaves to a nearby physician,¹ illustrate well both the medical thinking of literate rural Americans and the various roles of rural physicians. They demonstrate the kinds of illnesses for which people called the physician, the ideas people had about disease, the language they used to describe illnesses, the treatments they accepted, and the attitudes they held toward physicians.

Early nineteenth century Albemarle County, Virginia, home of the writers of these letters, boasted several prominent citizens including Thomas Jefferson and James Madison. Charlottesville, the county seat, was a small village in 1810, located in the Blue Ridge foothills some 100 miles southwest of the nation's new capital city. Most inhabitants of the county lived on farms or plantations where fertile rolling hills allowed the raising of tobacco, hogs, cattle, horses, and a variety of food crops. Dirt roads and paths through the countryside connected rural residences with major roads to Charlottesville and other towns.²

Charles Brown (1783-1879), the physician to whom these letters and notes were addressed, began practicing medicine in Charlottesville in 1812. One of only a handful of physicians in Albemarle County at the time, Brown found his patients spread over a wide area, making travel a time consuming part of his daily routine.³ The many letters Brown received requesting medical advice or information make it clear that the doctor and his clients used the written word to reduce the number of visits when possible. Brown gained and kept his patients' respect for the many years he lived in Charlottesville.⁴ During the early 1840's he even served as Albemarle County's sheriff.

In 1868 and 1869 Brown wrote some reminiscences of his life for the Charlottesville newspaper, *The Chronicle*, but said only a bit about his medical practice. He did posterity a much greater service by saving 153 brief notes on scraps of paper which he received from those in need of his services during his first few years in practice (1813-1818). Those notes are preserved in the manuscript division of the Earl Gregg Swem Library, William and Mary College, Williamsburg, Virginia.

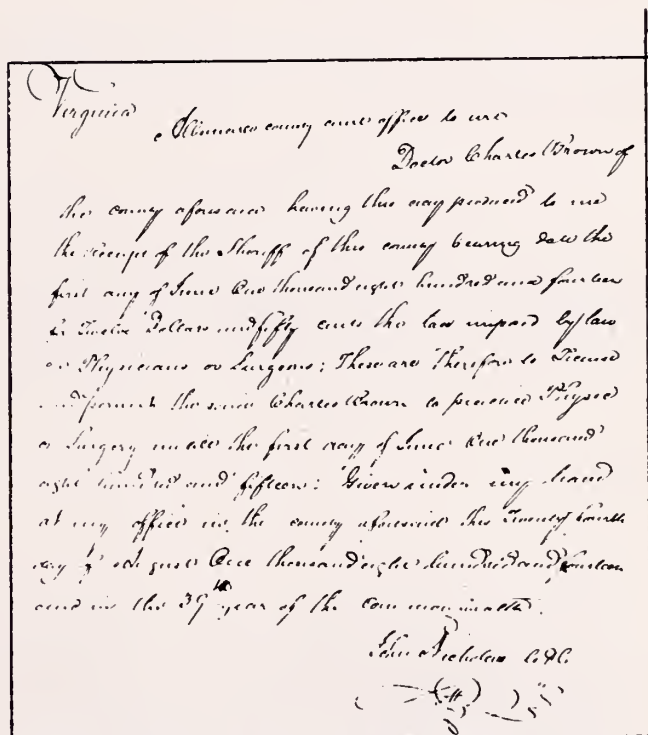


Fig. 3. — Dr. Brown's license to practice medicine in Albemarle County from 1 June 1814 to 1 June 1815. (Source: Charles Brown Papers, Swem Library, William and Mary College, Williamsburg).

Dr. C Brown we have a slave negro child about
 12 months old which has been com. down with a
 in some time & seems to get something better
 but I don't much hope. Some time we have very badly
 down morning same. Between 100 grains of Calomel
 2 or 3 times of 1/2 lb. - appears to offer the water
 in some quite green - this morning gave 20 grains
 of small dose that appears to work but not so.
 In some more green - the order in quantity
 strong with some blood & frequent staining
 which appears to give pain - the child seems to be
 with some fever - the pulse low & then rather
 slow - have but little hope of recovery yet showing
 but you would best Cap. Bezel's father has coming will
 say to you to come up if you can't come you will
 send him Medicine & such as you may think
 reasonable - Yours &c Bezeel Brown

P.S. I think the child will die but about me
 without an amendment 1817

Fig. 4. — Letter from Bezaleel Brown to Dr. Charles Brown, no date. (Source: Charles Brown Papers, Swem Library, William and Mary College, Williamsburg).

March 3d 1817
 Dr. C Brown Minor my Shop Boy Took the Measles about ten
 days past and appeared in a hopeful way — The eruption Disappear-
 ing — his fevers increas'd Skin dry Coughs frequent & harsh
 Complains of a pain in the Right Side of his Breast his breathing
 Considerable difficult — I have purg'd & Bled Bath'd in warm
 water &c.

NB I think his relapse was awakend by his putting on his Shoes
 wet after being mended — you will please to forward any medison
 with directson you may advise——

PS Should apply d a Blistering Plaster but had it not

Yours &c
 *Bez'l Brown

You Send by Some of the Neighbours Shoud you think not to come
 up. — you will please to name to the people in your [illegible word]
 that I have a few hundred Bushels of the paland white [illegible
 word] for Seeding - Sell Shoud they wont

BB

*[Bezaleel]

Doc.r Brow I have thought Proper to send my negro down for
 you to Examine him we have Bled him according to your direction
 and given him all the Powders and this is his day to be Bled and
 I am not a Judge of his Pulse we want to now what we are to give
 him to Eat. Your with respect

Tho L. Shelton
 March the 25 1814

March 5th 1817

Dr. my boy Minor — I think Dangerously ill The Blister drew
 well — the purge operated well I Bled him again last night with
 a ful & strong pulce The Blood much water with a large Cake
 The Boy Complains of much pane acrost his breast his cough harsh
 Breaths — Short and Ketchy his pulce quick — has always Con-
 siderable fever at times high — his Skin two dry — you will please
 to See him as soon as you Can —

PS Shall apply the plaster this morning to his Breast

Bez'l Brown

Dr. C Brown
 Charlottesville
 Pl[e]r Boy



Fig. 5. — Mt. Fair, home of Captian Bezaleel Brown. (Source: Mary Rawlings, Ante-Bellum Albemarle: Albemarle County, Virginia, [Charlottesville, 1935], p. 17).

Dr. Doctor,

I have a Woman who had a little one two weeks ago last night.
 She seam'd well all to what is common to Women at such times,
 stopt on her untill yesterday. They came on and today She was
 taken with a soreness and violent pains in her back & belly with
 chills which in the course of two or three hours moov'd in her
 stomach which brought on a sickness and pukeing & likewise a
 lax with it.

Would take it as a great favour Dr. *Doctor If you can come
 over with the boy to see her as I think theres great daingar without
 releaf.

Wm. Michie
 April 12th, 1814

* [Dear]

august the 11: 1818: Sir please to Look and See What is the
 matter with Old Sukey and write to me if you can do any thing
 for her Sir I am yours with respect John Watson

Charles Brown

the Negro Woman was about 2 months gone, She was taken about two weeks Ago with pains in her belly. A little discharge of blood every day, last night She was taken with severe flooding and puking, and to day her flooding is not so great She has fainty fits frequently and When She has these fits her stomach appears to have A quantity of phleme

Minoah Via
Oct 15 1818

Do if you please Let Capt Anderson Know I cannot attend Court this Weak

Minoah Via

Dr Sir Viewmont
I have a negroe complaining with a sworeness a cross the rim of his belley. & has been very [illegible word] for three or four day I wish you to come & assist him if you will ob Dr. Sir
Yr most ob

To Doctor Brown

John Harriss
9th Ap. 14

Charlottesville

P.S he has taken 4 spoonfull of easter oile and it doth not move him. he had a bad swoelling under his chin about 10 days Past and got about. & now complains as above decribed.

Dr Sir Viewmont
I have a negroe complaining with a sworeness a cross the rim of his belley. & has been very [illegible word] for three or four day I wish you to come & assist him if you will ob Dr. Sir
Yr most ob
To Doctor Brown
John Harriss
Charlottesville
P.S he has taken 4 spoonfull of easter oile and it doth not move him. he had a bad swoelling under his chin about 10 days Past and got about. & now complains as above decribed.

Fig. 6. — Letter from John Harriss to Dr. Charles Brown, 9 April 1814. (Source: Charles Brown Papers, Swem Library, William and Mary College, Williamsburg).



Fig. 7. — Viewmont, home of John Harriss. (Source: Rawlings, Ante-Bellum Albemarle, p. 13).

Dr Sir
I have a woman delivered of one child a day or two pass The midwife thinks there is [illegible word] conception to be gott from her. Ben is complaining very much of this Balley. I wish come with speed & shall be obliged to you to bring my news paper from the Post Office.

April 13, 1814
John Harris

July 15th 1816
Dear Doctor
My Negro Nathan Continues Bad I have bled him every day Since you were here I appyed the blister to his neck and then to his right side of which he Complained very much his pains have some abated he seems Costive at present I wish you to Ride up and se him if it should be too late this evening you will be so good as to come to morrow you Can send some thing by the boy to Release the Costiveness

Dr. Charles Brown Edmund Davis

Dear Sir
I have a negro woman in a very low state with the plurisy I think from her complaint she has a very sevear pain in her Right side with a little hacking cough has not much fever I have Bled her Several times she has Been Sick Nine Days please to consider her Case and Do what you think proper for her. I think she is in a very Danierous Situation allso wish you to Direct which side is the propiress[t] to Blead in in so doing you Oblige your Ob ser

James Douglass

Dr. Brown

Sir I have a Negro child that has ben complainen several days. I have given it a dose of Casteroil it is still poorly please to send some Medison by Andrew yrs

Thos. Garth
Jy 3d 1818

Doct C. Brown

I wish Doctr Brown or Doctr Jamerson would ride up & see a negro child, she is about two years old. She has a Lax & puking, nothing stays on her stomach. Several worms has been puked up if Either can come up will be glad how soon the horse the rode may be rode if more convenient.

Jesse Lewis
Augt 2nd 1814

[To Dr. Raglin]

Sir Liady Cumplains very much of the lump in her side — She thinks iff lff that could be removed she would get well. Her appetite is very weak She has high fevers of eavinings I suppos is what causes her thought to be soar — perhaps it would be well to get Mr. Brown to come up with you Iff you think so get him to do so. Yrs

Thos. Garth
Oct. the 25 1818

Mrs. Coles will be much obliged to Doctor Brown to visit a sick Negro she has immediately —
Enniscolby June 5th 1817

Doctor Brown

F 11th 1816 Sir the Negro girl is worse, I would be glad if you would come to see her come with the boy to Mr. Willis Garths to night and I will go on with you Wilson Mills

Mr. Brown



Fig. 9. — Headquarters, home of Captian Brightberry Brown. (Source: Rawlings, Ante-Bellum Albemarle, p. 18).

Dr. Sir-----20th of July 1815

Myra a Black Girl is very Ill She is between 8 & 9 years old She has constant fevers - last sunday She took her bed tho She had been complaining of her head for near week before her complaint is [illegible word] in her head we have tho't might possibly be occationed by a stroke patty Gave her with the Milkpail on her head which thought prevails Generally among the Negroes — I have not been of that opinion myself from the slight appearance of the wound tho have lately tho't it might be possible as her complaint seems to be intirely in her head & that of an Inflamitory nature last tuesday her face and head swell up like a hornet or some such thing had stung her & has been considerably swollen ever since. She complains of her head being very sore to the touch She head which thought prevails Generally among the Negroes — I had not been of that oppinion myself from the slight appearance of the wound tho have lately tho't it might be possible as her

NB You will be so good as to send what you think necessary —

Dr. C. Brown

Dr Sir — 20th July 1815
Myra a Black Girl is very ill She is between 8 & 9 years old She has constant fevers - last sunday She took her bed tho She had been complaining of her head for near week before her complaint is [illegible word] in her head we have tho't might possibly be occationed by a stroke patty Gave her with the Milkpail on her head which thought prevails Generally among the Negroes — I have not been of that opinion myself from the slight appearance of the wound tho have lately tho't it might be possible as her complaint seems to be intirely in her head & that of an Inflamitory nature last tuesday her face and head swell up like a hornet or some such thing had stung her & has been considerably swollen ever since. She complains of her head being very sore to the touch She head which thought prevails Generally among the Negroes — I had not been of that oppinion myself from the slight appearance of the wound tho have lately tho't it might be possible as her

Fig. 8. — Letter from Brightberry Brown to Dr. Charles Brown, 20 July 1815. (Source: Charles Brown Papers, Swern Library, William and Mary College, Williamsburg).

[July 1816]

Dear Doctor my Negro Nathan Continues Bad his Nose has not bled any to day he is Costive no passage since you were here he inclines to sleep a good deal I wish you to Come up and see him perhaps it would be best to Come to night or early in the morning I expect he woul[d] be better of having his Nose unstopt. the Barks are out.

Edmund Davis

Dr. Charles Brown

Sir One of Capt. Garth's Negroe woman was taken in labour this evening — the child has presented its self in such a position that it is found Impossible to deliver it without the aid of Instruments If you have any, you will be so good as to lend them, of If convenient come with the boy.

Yrs — Thos. K. Clarke

Dr. Charles Brown
August 31st - 1814

If Dr. Brown has not got any, to
Borrow Dr Raglands

May the 26th 1814

Dr. Sir. Moses appears much Easer in the Day than when you Left him But he says he rests Badly in the nite. the swelling appears about the same - he says there is not simular to wheelks that forms on the side he complains of in the nite & disappears in the morning. I have not had him bled sence you bled him owing to his fevour not being very high. I will thank you to send me a vial of Casteroil. I will be glad you would rite to me respecting moses and oblige yours &c

G. Garth

Dr Sir, I have made but little use of the Instruments - the womans situation is such that for my Satisfaction as well as for that of the family's they wish you to come as quickly as possible.

Yrs &c — Thos. K. Clarke

Dr. Chas. Brown
31 August 1814

Dear Sir,

If convenient you will please attend a negro man of mine who has some symptoms either of the dropsy or a very severe cold. I will thank you to bring a box of ointment for the itch.

Yrs &c &c

Augt. 16 1816

Garland Garth

Dear Sir

I come to you to inform you that I have a little negro very badly burnt and wish for you to come and see it I think its arme will have to be cut off[] above the elbow the child is about 4 months olde the goint appears like it will drap off[] I am yours

September 27th
Jemima Fretwell

Febuary the 9th 1817

Dr Sir the woman sarah that was to see you still Complains smartly of her eye her lip and nose has got nearly well you will be pleas to send medison and direction as you may think best also a puke for Jim the Buoy that had fits I am yours with respect Garland Garth

NB I saw Capt Brown to D[ay]
he is much mended

Dr. C Brown we have a Small negro child about 12 months old which has been complaining with a lax Sometime & Seemd to get Something Better till about a week past Since have been very poorly yesterday morning gave Between 1 & 2 grains of Calomel & a few grains of Gallop — it appeared to operate well the ordure quite green — this morning gave 20 grains of Thistle seed that appeared to work about right also the ordure Still green—the ordure in generally Slimy with Some Blood & frequent Straining which appears to give pain—the child much troubled with Some fever—the pulse low & think rather Slow—I have but little hope of recovery yet hearing that you would be at Capt. Jno. Rodes this evening — will thank you to come up & [if] you cant come — you will send such medicine & direction you may think advisable-

Yours etc. Bezaleel Brown

Sir

I have a Negro Woman in a Strange way so the Old Woman say some say She is Pregnant she Denies there fore I think it best to Request you to come and see her which I would be glad you could do as soon as Possible

am yours &c Jas. Old

Doct Brown

P.S. I think the child will live but a few days without an amendment B B

References

- 1 Todd L. Savitt: *Medicine and Slavery, The Diseases and Health Care of Blacks in Antebellum Virginia*, Urbana, Ill., 1978.
- 2 John Hammond Moore: *Albemarle: Jefferson's County, 1727-1976*, Charlottesville, Va., 98-99, 177, 1976.
- 3 Charles Brown "Dr. Charles Brown's Reminiscences of Early Albemarle," *Papers of the Albemarle County Historical Society*, ed. Mary Rawlings and W. Edwin Hemphill, Vol. VIII, 60, 66, 1947-48.
- 4 *Ibid.*, 59, 62.

Acknowledgement

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Health practices in Collier County: a study in diversity and contrast

William W. Cox, M.D. and Roger J. Evans, R.N.

Archeological interpretation of data resulting from studies of artifacts found upon excavation of burial sites in southwest Florida, part of which is now Collier County, suggest that this area was inhabited by semi-nomadic peoples prior to the birth of Christ. Archeologists using the carbon 14 dating method in studying artifacts from burial sites at Caxambas, Marco Island, have established habitation there as far back as 1450 BC-1140 BC. Recent paleopathological studies (1980-81) of a prehistoric burial site near Naples, in Collier County, have shown that dental and skeletal defects induced by such things as the lack of medical care and the consequences of primitive living, i.e. stress, malnutrition, infection, trauma, etc. were widespread among peoples of this period. The average life span in these times has been estimated to be between 40-50 years.

Primitive medicine • Not much is known about medicine or the role of the medicine man during this period. It was not until the Spanish contact with the Calusa Indians of southwest Florida that the activity and position of medicine and the medicine man began to be understood and appreciated. Historical research has made clear that the medicine man, in the parlance of today, was the private practitioner-public health physician of these times. The Calusa

medicine man was in possession of a large number of root, berry, bark and herb cures which had been passed down to him from previous generations and would in turn, be handed down by him to his colleagues of the next generation. Actually many of our present day drugs—salicylates, quinine, bella donna, curare, etc., were old medicine man trade secrets which have been rediscovered by the white man.

Many of the primitive cures were administered by the medicine man as a form of preventive medicine during the tribal festival times. For example, one day of the festival might be devoted to the taking of purgatives in the form of "the black drink" or on another day to the utilization of heat and sweat baths on a community basis. A widespread technique for the prevention and cure of illness was found in the practice of blood letting. The medicine man, using a sharp mussel shell or bird claw or beak, would scratch the leg or arm of the patient until a free flow of blood was established.

The discovery of many of these ancient artifacts and from legends handed down suggest that the Calusa medicine man had a capability in a number of areas of medical practice. He could perform minor surgery, set fractures and assist in certain birthing procedures. Many of the customs of the "clean and unclean" such as those dealing with food preparation, sanitation practices, personal hygiene, etc., associated with ancient Semitic peoples, were known to and practiced by the medicine men of the Calusa tribe.

With the coming of the Spanish in the 1500's the future and destiny of the Calusa became threatened. The Spanish military operations, smallpox, the "flu", venereal disease and the inability of the tribe to develop a competitive political and economic base . . . all combined to spell the

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doom of the Calusa nation. And so the Calusas, a fierce, independent, intelligent and culturally advanced people, disappeared from southwest Florida to be remembered by only their legends, artifacts and enormous shell mounds.

Following the demise of the Calusa nation, the Seminole Indians moved into southwest Florida during the Seminole wars (1835-1855). The Seminoles were less warlike and more agriculturally oriented than the Calusa. They maintained, in general, the tribal organization and social structure common to other Indian tribes along the Atlantic seaboard. The medicine man was in the same position of respect and authority as he had been in the Calusa tribe. This organization persists to some extent, even to this day in the Seminole nation.

There can be little doubt that the medicine man was a dominant force in the society and culture of the Calusa and Seminole nations. He was revered and respected by members of the tribe, not only for his medical prowess and accomplishments, but also as a tribal counsellor, spiritual leader, judge and law giver. As such, he was, indeed, a fitting predecessor of our present day practitioner of the healing arts in Collier County.



Dr. Jacob E. Brecht



The Glades Cross Mission at Boat Landing
(Brown's Trading Post)

The period of emerging modern medicine • In 1845 the Congress of the United States granted statehood to that region of the United States now known as Florida. In spite of the lack of roads, transportation, communication, medical facilities, etc., the area of southwest Florida continued to prosper and grow. In the 1850's the Federal Government placed most of the Indian lands in southwest Florida under the jurisdiction of the State of Florida. In 1887 the State Legislature, at the urging of residents in the Fort Myers area, created Lee County which became the largest county east of the Mississippi. Administration of this large county was difficult and in 1923 a group of citizens led by Barron G. Collier convinced the Florida Legislature that the subdivision of Lee County into two more political and geographic units, Collier County and Hendry County, was politically, administratively, and economically desirable.

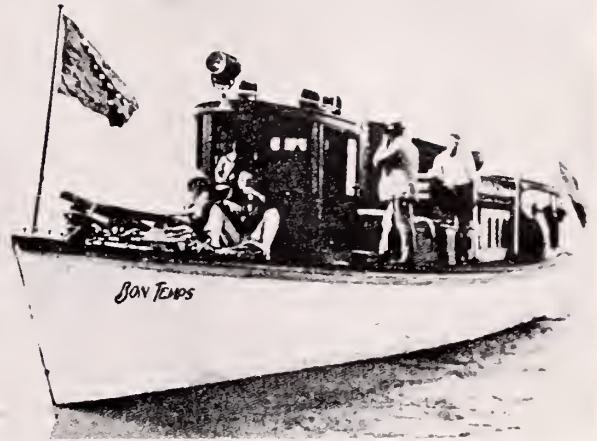
The first health care effort came into the area later to be Collier County in June 1891. Two medical missionaries, Dr. and Mrs. Jacob E. Brecht, started a mission located on a 400 acre plot of land which had been purchased by the Women's National Indian Association. The mission, called Allen's Place, was located 40 miles west of Immokalee and was established to provide medical care, spiritual education and technical training to the Seminole Indians and other settlers in the area. The location of the mission, however, proved to be unsatisfactory and in 1898 it was moved to an area in the vicinity of Boat Landing, also known as Brown's Trading Post. Boat Landing was strategically located for providing services to the Indians and other water travelers as it was at the head of the canoe navigation route on the western edge of the Everglades. This newly established mission, named the Glades Cross Mission, was comprised of a store, a small clinic and a lodge.

Dr. Brecht and his wife, a trained nurse, were activists and they devoted much of their lives' energies to serving the Seminole people both politically and medically. In his writings and reports Dr. Brecht noted that as the Indians adopted the life style and diet of the white man, they also became susceptible to his diseases and, in particular that "La Grippe" (flu) was occurring with increasing frequency in his practice. He also reported that the mortality rate of Seminole children under six years of age was unusually high. He thought this was due to exposure and to the rather common habit of eating clay, ashes and trash, a practice not unheard of even in more recent times and thought to be related to a nutritional deficiency.



Deaconess Bedell with Doctor Tiger, 1936
(courtesy of Smithsonian Institution)

Dr. Brecht was succeeded at the mission by an English missionary and pharmacist, Dr. W. J. Godden, who operated the mission until his death in 1914. There was no replacement for Dr. Godden and the Glades Cross Mission remained inactive until 1933 when the mission was closed at Boat Landing and reopened in Everglades City by an Episcopal missionary, Deaconess Harriet M. Bedell. The Deaconess operated the Glades Cross Mission until 1960 when Hurricane Donna smashed across the Keys and devastated the town of Everglades City, including the mission. The Deaconess remained active in her ministry until her death at the age of 93 in 1969.



Best route from Naples to Ft. Myers in the 1920's

Collier County with its slightly over 2000 square miles of territory, the second largest county in the state, was without a hospital for its approximately 1200 inhabitants until 1923 when the Collier Corporation established the Juliet C. Collier Memorial Hospital in Everglades City, then the county seat. The hospital was established primarily to care for the employees of the Collier Corporation. However, by special arrangement with the first Board of County Commissioners (1924), the hospital would also care for county employees, jail inmates and others, but only by special approval of the Board. Hospital care could also be obtained at Fort Myers in Lee County, however, until 1928 when the Tamiami Trail was opened, access to Fort Myers was difficult and primarily by boat. Miami was not considered a reasonable source of medical care for Collier County residents because of distance and transportation problems until well after the opening of the Tamiami Trail.

With the development of Collier County and the opening of the Tamiami Trail, the availability of medical services proceeded at a rapid pace. Early in the development of the county, much of the medical



THE ROAD FROM FT. MYERS to Naples was atrocious in the 1920's. The trip took several hours and usually required at least one stop to repair a flat tire. In this case the bus had taken to the shoulder to allow another car to pass and became stuck in the sand.

Travel by land from Naples to Ft. Myers was atrocious in the 1920's

support for the Naples area was provided by physicians who came to the area on a seasonal basis to provide medical services to guests of the Old Naples Hotel, the "Snow Birds." During their winter stay these physicians were available for services to the residents of Naples and the county. During this same period, qualified physicians recognizing the climate attractions and the professional opportunities of the Naples area began establishing their own medical practices.

Establishment of the County Medical Society • In 1957 the American Medical Association requirement that a county must have five qualified practicing physicians in permanent residence prior to the issuance of a county medical society charter was met in Collier County. Dr. Francis H. Langley, president of the Florida Medical Association, presented the Charter to Dr. James Craig, president of the new ten-member Collier County Medical Society. Twenty-five years later the society has grown to a membership of over 125 physicians.



The Juliet C. Collier Hospital, Everglades City
(center building is the hospital-clinic)

Basic hospital services were provided to Collier County residents and visitors by the small Juliet C. Collier Hospital in Everglades City and by hospital facilities in Fort Myers, 40 miles away. Emergency medical treatment and hospitalization for Collier citizens were inadequate until the opening of the well equipped 52 bed Naples Community Hospital in 1956. Growth has been rapid and in 25 years the hospital has evolved from a 52 bed facility with a small staff of physicians and limited services into a modern 350 bed structure. The medical staff now numbers over 115 physicians providing all major speciality services except open heart surgery. Inasmuch as Collier County is a very large county with over 2000 square miles, and Naples Community Hospital, the only hospital in the county, is not centrally located, two satellite medical units are being developed. One is in the northern part of the

county near Bonita Springs and the other on Marco Island in the southernmost part of the county. These units are designed to provide emergency medical services, outpatient services and limited inpatient services more convenient to people in the area. The development of Naples Community Hospital and its satellites into one of south Florida's finest medical facilities over a relatively short period of time is a tribute to the outstanding foresight, planning and leadership of the Staff and Board of Trustees of the hospital.

For many years after the establishment of the Juliet C. Collier Hospital in 1923, the physician in charge of the hospital acted as the County Health Officer. He submitted annual reports to the Board of County Commissioners in which the general health status of the medically indigent and county prisoners was discussed and requests for budgetary support were made. This makeshift system of public health in the county persisted until 1952 when the Board of County Commissioners, in cooperation with the State Board of Health and the Board of County Commissioners of Lee County, created a Collier County Health Department. By agreement with the Lee County Health Department, the Lee County Health Officer visited Collier County twice a week, making stops at Immokalee, Everglades City and Naples on each visit. The Collier County Health Department at that time was based in one room in the courthouse in Everglades City. The department was staffed by a full time sanitarian, a nurse and a clerk who worked under the direction of the Lee County Health Officer. This arrangement was terminated in 1960 with the formal organization of the Collier County Health Department as a separate and independent county health unit. Dr. Clarence Pearson was named as the first director of this newly organized unit. Because of a shift in the center of population and political gravity away from Everglades City i.e. to Naples, the county government and its agencies were moved to Naples in 1960. From a small county health unit with three authorized staff members in 1952 occupying one room of 250 square feet in the courthouse in Everglades City, the Collier County Health Department has grown until it now utilizes over 11,000 square feet of space with an authorized staff of 81 positions. The mission, organization and operation of the Collier County Health Department is similar to that of other coastal county health units throughout the state.

The period of changing morbidity and mortality patterns • Many medical, economic and social forces have acted independently and in combination to significantly alter the morbidity and mortality patterns in Collier County since its organization in

1923. These changes, for the most part, may be considered as an indication of the progressive medical conquest of disease and the control of health risk factors in our environment.

Statistical analysis of the occurrence of communicable disease in Collier County over past years has shown that, with few exceptions, there has been a general decline in the incidence of infectious disease and the mortality rate therefrom. This can be attributed in part to: the improvement of environmental and sanitation factors; more aggressive and widespread immunization practices; the improvement in economic, social and nutritional factors; and the availability and accelerated progress of the healing arts and sciences in the diagnosis and treatment of these diseases.

Unfortunately the morbidity and mortality rates in Collier County from causes other than infectious disease have tended to increase because of demographic changes, especially in the area of the population mix. In 1960, for example, only 8.2 percent of Collier citizens were over the age of 65 while at the present time over 20 percent of our citizens are in this category.

Facilities for the care of senior citizens in Collier County have more than doubled in the past ten years. This is consistent with the fact that some of our most pressing medical problems are currently in the area of diseases associated with the aging process, i.e., hypertensive cardiovascular disease, stroke and its sequelae, cancer, mental health problems, diabetes, arthritis, etc. Morbidity and mortality statistics over the past ten years in Collier County seem to reflect this changing medical spectrum.

Changing social mores over the past ten years with the increased acceptance and practice of promiscuity along with problems associated with drug abuse have introduced a new group of medical problems especially in the teenage group. Sexually transmitted diseases and teenage pregnancy have become rather common place today in Collier County. Fortunately control of these problems is now recognized not only as a medical responsibility but also as a social responsibility of the entire community.

The changing ethnic features of the county have significantly influenced the disease picture not only in terms of the types of disease but also in terms of distribution of these diseases. Collier County, along with a large part of southern Florida, has recently become a veritable ethnic "melting pot" as a result of significant influxes of Indonesian, Haitian and Cuban refugees. These groups, when considered along with the already large Mexican migrant population, create a uniquely complex health maintenance problem for county and state public health workers. On entering the county, the new migrant workers and the refugees bring with them



The Naples Community Hospital, 1981

the medical problems that exist in their homeland. By and large, these emigres are in the young to middle age group and bring with them dental and nutritional problems, tuberculosis and sexually transmitted diseases. In addition to these diseases, the Haitians have broadened the medical spectrum by the introduction of potential public health problems associated with hepatitis B, especially in females, and with filariasis.

As the county has developed, the dichotomy of the increasing sophistication of the urban civilization with its highly developed modern medical facilities, equipment and medical specialization in the Naples area contrasts sharply with that of the rural and less highly developed medical capabilities in the Immokalee area. In this area and its environs are found three rather distinct groups of people which impact on the medical spectrum. First, there are the migrant workers numbering about 10,000 who live here on a permanent basis and who only venture out of the county once or twice a year. This movement is necessary to maintain their migrant status and to seek work because of a slack season in local agricultural activities. This group has been assimilated into the medical ecology of the county and, except for being a younger and ethnically different group with larger families, do not differ significantly socially or medically from many other residents in the area. A second group of people, estimated to number 8,000-12,000, are those seasonal agricultural workers who are truly transients and whose annual stay will range from four to eight months depending upon available work. Members of this group are frequently economically and socially unstable. They have introduced into the county a disease picture of malnutrition, mental instability, alcoholism, tuberculosis and sexually transmitted diseases. Children in this group often suffer from lack of parental guidance and care in the area of nutrition, immunizations, childhood diseases and schooling. This group with their "flopouse" style of living have presented serious

medical problems that are not evidenced in the more affluent western area of the county. A third group are those who may be termed "refugees". These are primarily Haitians with a sprinkling of Hispanics. Outreach workers have estimated 3000-4000 persons are in this group. These people have introduced acute demographic and ethnic considerations into the epidemiological picture of the county disease spectrum.

The Immokalee area is over 50 miles from the Naples medical facilities and has an inadequate public transportation system. Despite this handicap, management of these medical problems has been mitigated by the Collier Health Services Clinic in Immokalee; the county-wide public health services; the availability of 24-hour emergency ambulance services and the emergency room facilities at the Naples Community Hospital.

The Haitian migration into Collier County began in 1979 when approximately 1500 were sent to the Collier County Stockade in Immokalee from the entry station in Miami for processing and medical screening. Following the screening process, they were returned to the Miami area for further disposition. Many of these people later returned to the Immokalee area in search of better economic and social prospects. From the records that are available and from remembrances and diaries of those who were active in the screening process, it is evident that there was a high incidence of tuberculosis, malnutrition, sexually transmitted diseases and intestinal parasitism in this group.

Available statistical data indicates that this group has contributed significantly to the incidence of venereal disease and tuberculosis in the county. For example, it has been shown that in 1981 twenty-seven percent of the individuals entered into the tuberculosis program in Collier County were Haitians. This is put into better perspective when one realizes that the Haitians constitute approximately three percent of the county population. Similar statistical data has been derived showing that the Hispanic group is also a significant contributor to the incidence of tuberculosis in the county.

A recent epidemiologic study of tuberculosis and the migrant life-style based on observed cases in Collier County, population data and the Florida Morbidity and Mortality rates indicates migrant origin and life style are determininants in the acquisition of an active case of tuberculosis. The relatively large migrant population and the dynamic movements of migrants may help to explain the fact that the attack rate of tuberculosis in Collier County has been found to be two and a half times greater than the rate for the state for a similar period.

Other disease processes brought in by the Haitians but perhaps not as important as tuberculosis and social diseases, are the hepatitis B carrier state,

especially in female Haitians, and the finding of a six percent filaria (*Wuchereria bancrofti*) infection rate in over 200 Haitians who were examined. These diseases are not thought to be an immediate public health problem but may be of potential concern in the future.

Collier County has been fortunate that in 1977 the Federal government established and funded the Collier Health Services Clinic in order to provide medical services to the rural poor and migrants in the Immokalee area. Since its establishment, this clinic has provided the bulk of medical services to the people of the area. The Federal government has funded this clinic at the rate of over two million dollars per year since its beginning. Recent cutbacks in Federal medical programs are a cause for concern since the rural poor, the migrants, the refugees and their medical needs are not going to go away. The situation in Collier County, with the prospect of diminishing federal, state and county funds is going to get worse. This is a politico-medical problem of our times that is not unique to Collier County but is also found in many other counties where there is a large concentration of emigres. This problem calls for an immediate maximum effort of federal, state and county, political and medical leadership in seeking its resolution.

Summary • With the end of the period of the tribal medicine man—the first practitioner of the healing arts in the area later to be known as Collier County—and the arrival of the first medical missionaries in the area in 1891, the first stage in the development of modern medicine in Collier County had begun. Since these early days the changes in the morbidity and mortality patterns have been rapid and significant.

Initially, the disease patterns were dominated by the infectious processes and their sequelae. With the conquest of medicine over infection, the morbidity and mortality picture in Collier County significantly changed. Other factors in this change have been medical advances in general, improvement in the socio-economic conditions, demographic changes related to migrants, refugees and changes in the population mix. In the last 10-20 years, the increasing numbers of senior citizens with the medical problems secondary to the aging process, i.e. hypertension, heart disease, stroke, cancer, diabetes, etc., and the ever increasing health risk factors presented by the influx of refugees and migrants have fundamentally altered the thrust of medical practice in Collier County.

The most distinctive characteristic of medical practice in Collier County over the last half century has been that of constant, rapid and challenging change associated with effective and successful

response by the medical community in meeting the needs set in motion by these changes. However, we still have ". . . miles to go before we sleep".

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The Doctor who practiced in Miami

Franz H. Stewart, M.D.

Time, as a sense of duration, a perception of interval between events tends to fade as we look backwards, but perhaps a view of the doctor practicing in the 1930's can be captured and held for a moment. The circumstances and the feelings of the time, the milieu in which he worked, dictated the way he lived, thought and practiced medicine here in South Florida, in Miami.

Miami beginnings • Our young doctor, a composite figure of imagination and memory, found himself in Miami. Just why he had come would be hard to answer but he and his bride had simply started out. It was almost dark as the locomotive, puffing a cloud of smoke, sounded the whistle and the cars began to move, accompanied by the clanking of the couplings. Charlottesville and family good-byes receded with the station, and excitement took over — the excitement of having started on the road. Where would they stop? Neither knew, but land they would.

The rum runners were gone and prominent citizens no longer went to the door in the evening to meet the bootlegger. Miami was a new town, a new beginning — clay which had not yet taken form.

Coconut Grove had changed very little. The long-time winter residents lived as they always had, enjoyed their homes along the Bay, and usually left for the summer. The one-man Boston-Miami Clinic furnished friendship and a good brand of medicine to most of this flock. The building was closed in the summer and the doctor away in Boston for medical refurbishing and hospital work. Coconut Grove

looked with interest at the development on Miami Beach, but kept it's distance.

Miami Beach was magic tinsel sprung from the swamp less than ten years before. It had somehow survived the bust of the land boom, the hurricane of 1926 and the worldwide depression. The Depression was the common pervasive fear of everyone.

Winter doctors • There were doctors who practiced almost exclusively in the hotels during the several months of the winter season. There were whispers that fees may have been collected from the desk clerk or patients otherwise billed by the Hotel. Some even wondered if kickbacks, or other emollients in the right place, may have helped land these lucrative hotel jobs.

No one really knew if such schemes involving business arrangements related to medical practice could really be going on. These doctors were accused by some of dealing financially with a third party and not directly with the patient. This was not as bad as those who practiced on the fringe, who were in the black market and did abortions. These well-dressed, pleasant men were spoken to politely but there the contact ended.

Beautiful houses decorated the beach and lined the well tailored roadways. Here lived the winter residents of the beach, here for a few months, a home away from home. Practicing medicine among these prominent elsewhere people were several excellent doctors who enjoyed a polite visit in the living room of each home as they made their round of house visits. There was reference to the doctor back home, or the medical institution they looked to, or perhaps the crash of 1929, or the depth of the Depression. Re-assurance was given, a friendly contact maintained,

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arrangements made for the follow-up visit and the prescription given or phoned to the nearby druggist. The doctor was independent of the rest of the burgeoning community. He was rarely seen in the summer.

Building a practice • The doctors in Miami proper were in circumstances quite different from those in Coconut Grove, those on the Beach, or those developing outlying community practices. Most of these men had come to Miami, perhaps attracted by the fireworks of the land boom. They had the courage, the tenacity to stay on, to survive the hard times and build a practice. Much more than this, a city was to be built! Worthwhile medicine and medical excellence had to be developed. This was their town and they would see it survive and survive with it!

These determined men were individualists, theirs were solo practices. Some worked in cliques and rarely stepped beyond, except perhaps in medical community projects. These men were a new breed of medical men for Miami and with them started the rumblings of what was to become modern medicine. The ground was set and the welcome out to bright, highly-trained and well educated young doctors.

From the Democratic Convention in Chicago came a confident, resonant voice. "This convention wants repeal! Your candidate wants repeal!" With this battle cry, Franklin Roosevelt was elected. Prohibition was ended. Now started a series of social measures, which gave reassurance but did not end hard times. This trend cast a shadow which would have a dominant influence on the way a doctor practices, upon his position in the community, and upon the pressure and anxiety he experiences.

First impressions • Our young doctor arrived in the midst of this and felt the challenge immediately. Here were a group of men ready to welcome the efforts of just such a highly trained, well educated young man. The welcome, encouragement and hospitality of this group sealed the decision to land!

Let our young doctor speak for himself. "I stepped into the radiologist's office on the eleventh floor of the Huntington Building in downtown Miami. Dr. Charlie Cleghorn and Dr. Nelson Pearson were there. Several doctors were sitting around playing cards, right in the middle of the day — the game was gin rummy, I think. Records of winning and losing were kept, week after week, but accounts were never settled. A surgeon joined the group. 'Where have you been all morning?' 'Oh, I've been making rounds and operating on the service out of Jackson.' "

There was no hurry, time was plentiful and patients scarce. Those patients who came would like to pay, if only they could. The real work, the time to earn was during the brief winter season, those two or three months, January to March when the tourists were here and supplied enough patients

and dollars to go around. The rest of the year there was little to do. The end of the season took many of the doctors North and those who stayed on found a few patients to spread among a smaller group of doctors. The doctor was asked, "Where do you go for the summer?" "Oh! I stay here!" "How can you? Isn't it very uncomfortable?" and then with some disdain, "So you live here!"

Practice in Key West • A good break came. There was a telephone call from Key West. The Treasury Department ran a Marine Hospital there to take care of merchant seamen. A doctor to take the medical wards was needed. Our young doctor grabbed at this.

The train from Miami to Key West had empty seats until the stop at Matecumbe Key where the Bonus Marchers had been transplanted from Washington. These veterans of World War I would ride the train down to Key West over the weekend for diversion and excitement. Some would partake of the available alcohol a little bit too much and all too often the Marine Hospital would find itself host to numbers of these men suffering various types of disappointment, confusion or injury.

The train puffed on towards Key West. The varicolored waters of Florida Bay, seen out the window of "the train that went to sea" over the seven mile trestle, captured attention away from the noisy, boisterous weekend celebrants from Matecumbe. The doctor watched the grey forms of large fish, lazing along over the sand bar, his view not hampered by the crystal clear water.

As the fish disappeared in the background, the doctor let his thoughts wander back to Miami and his decision to take out professional liability insurance, just a precaution against the unlikely possibility of a malpractice law suit. The annual fee seemed an awful lot to pay but somehow he would come up with the fifty dollars.

He stepped off the train in Key West. Here there was quiet, a unique quality of unhurried contentment with things as they are, as they had always been, and yet at the same time business was in the doldrums of the Ancient Mariner. The only recognizable source of income was the Federal Emergency Relief Administration. The FERA pumped funds in from Washington to keep the town alive, yet added one more social program, another cost to Uncle Sam.

Old families, perhaps a dozen or so, touched the outside world, but lived, thought and measured themselves by Island standards and relationships. Stalwart ladies bringing pride, courage and kindness came to call on the young doctor and his bride — flowered hats, white gloves and all.

Here a language other than English could be heard. There were cigar makers, sponge fishermen and others who spoke Spanish and lived separately from the descendants of the old wreckers or salvagers who aided the ships aground on the reefs.

Miami comparisons • In Miami, there was bustle, uneasiness, change! English was the only language heard. The drawl of Georgia accent mixed with the sounds of New England, New York and the Midwest. Backgrounds were similar, mostly English, Scotch, Protestant, people who had come to America because of hard times, or to find a new life. Now their descendants in similar circumstances, were in a new town, a new beginning, in the turmoil of building and social change.

Blacks lived separately. In the Jackson Memorial Hospital there were separate wards and operating rooms for blacks, but no black doctors. In the clinics the same segregation existed. One doctor had two entrances and two waiting rooms in his office and those who came in one door would be dismayed to see those who came in the other door!

In the hospital at Key West the doctors were better than the equipment. On one occasion the only functioning x-ray was that in the dentist's office. On rounds one of the patients was found to have a painless node in the neck, a Virchow's node. The dental x-ray revealed a constrictive lesion in the esophagus.

Back in Miami now, his office open, plenty of work on the wards but few private patients, few were referred and the season was a half year away. The doctor helped in pathology doing the autopsies at Jackson, as a volunteer of course.

Working through a Hurricane • It was late in the afternoon the first Monday in September 1935; there was warning of a coming hurricane. The little white cottage made from Dade County pine was battened down as tight as possible, but the rainy, dark afternoon was foreboding. She heard it first, a lonely whistle, the whistle of a train heading south. A plaintive whistle.

In Miami the well planned Hurricane Relief Organization was in full swing. Memory of the 1926 hurricane urged each one to be prepared and ready to assist wherever needed. Doctors joined others and offered help wherever possible and with the rain and screeching wind, watched through the night.

The full force of the wind and ocean had swept over the keys. The Bonus Camp was gone, houses were gone, people drowned; the survivors — many of them injured — were isolated without food, shelter or fresh water. A small plane with a doctor aboard surveyed the damage, landed and brought back accurate information upon which rescue operations could proceed.

The church in Homestead had served as a refuge overnight but now was receiving stragglers coming up from the keys, some with wounds to sew up, all of them hungry and needing clothes. Many were searching for loved ones lost in the storm. The doctors were busy with minor surgery and triage for rescue and transport to Jackson Hospital.

A characteristic mark or wound could identify each person who had lived through the blast of wind, water and sand. Turn the ear lobe forward and there the skin surface was denuded, quite raw. Imagine the hunched over person his back to the wind, ears bent forward and peppered raw.

Back in Miami times were still hard, lack of money remained the problem. One of the pioneer doctors, that is, one who was practicing prior to the boom, had taken care of a man and his family for several years and had never charged because he knew there was no money. Many months passed and the doctor didn't see his patient. He met his patient on the street, apparently feeling fine. "Hello, how are you?" he asked. "Oh Doctor, I would like you to know I fell on better times. Now I don't have to go to a free doctor; I have been going to a charging doctor."

Another patient was a delightful lady of 70 years, refined, kindly and proud. After a careful history and physical examination, it was apparent that x-rays would be required. How could this be accomplished? Who would pay for it? In conversation the doctor learned she had no way of paying anything. He suggested she have the x-rays at the clinic at Jackson and that this could be done without cost to her. The lady was indignant, "I would never accept charity!" What was a doctor to do? This was a daily problem for him. Socialization had not yet coined the word medicare.

Worldwide events • After some fifteen years, the shadow of WWI still streaked across the land. "The Lost Generation" of that war was still trying to find itself in a new world. Edwardian customs were buried in fond memories. The Crowned Heads were gone. People searched to fill this void, and the worldwide depression darkened the landscape.

The shadow of WWII stretched back across these years overlapping the shadow of WWI. People searched in all directions for assurance, for some order, for any remedy. These times gave birth to Communism, Fascism, and led to the despotism of Stalin and Hitler — to the inevitability of World War II.

These were the days in which the doctor lived, kept to his ideals, worked and yet his life was dominated by these world changes. Miami was an ideal place to be starting. A city was beginning, was building, and pointed direction for the doctor's effort.

Keeping up with medical advances • Could one live and practice in a town isolated way down at the tip of Florida and still keep up, be on top of things? St. Francis and Jackson Memorial Hospital staff meetings gave a chance for communication with colleagues. Case reports or papers could be read. Lively, stimulating discussions would ensue from ward rounds or among friends comparing notes on patient problems. The doctor was sure that medical practice, as a life of study, education and self-improvement

depended on individual motivation and could be accomplished in one place as well as another.

The Journal of the Florida Medical Association and the *Dade County Medical Society Bulletin*, along with the national medical magazines were available. The seasonal practice in Miami gave an opportunity to visit distant medical facilities or to attend an occasional national meeting.

The real stimulus came from the desire to learn everything possible from each case treated, the details of the problem, the pathology, the related physiology, the historical and community relations and the patient's own reaction. Methods of treatment and management could be sought, chosen and questioned.

These were the techniques used and they worked. The content of hospital staff meetings improved and group learning sessions developed. The doctor was right.

Sunday morning conferences became a regular weekly event at Jackson Hospital. As ten o'clock approached, physicians collected from miles around to get together and share a learning and teaching program. This effort represents the first formalized teaching in South Florida medicine. As many as 50 doctors and occasionally 70 would appear and participate in these programs in the library.

The meetings started promptly at ten and never went beyond eleven. The teaching method was an adaptation of the ever popular Clinico-Pathological Conference. The presiding doctor picked a case and with the help of a member of the House Staff prepared a one page resume for distribution to those in attendance. The leader planned to bring out two or three points of interest during the program.

One man, usually a different one each Sunday was chosen to discuss the case. The two stood together and worked together, to encourage discussion from the whole group, to tactfully guide the discussion in such a way as to bring out the important points. At times there would be a case that was a true Clinico-Pathological Conference but the idea was to learn the clinical aspects and not just try to get the right answer. At times there would be a surgical case in which the answer could be given from the surgical findings. Occasionally there would be one in which the answer was not available. In this way free discussion would be accomplished.

These developments and constructive efforts in Miami kept the doctor and his friends busy and gave direction to energy.

The shadow of World War II became more and more ominous and claimed the attention and thoughts of all. Daily work continued but was interrupted more and more by broadcasts of news from Europe and Asia. Soon the doctor's whole effort was directed by the approaching catastrophe. The fading shadow of the First War, with the great voids it left, became

more distant and the enveloping cloud of the new blotted out thoughts of the invading social program in America. Suddenly the all consuming reality of war burst over the world! World War II was fought to stop the aggressor and preserve the dignity and freedom of man.

Social programs • The social programs born in Chicago the day Roosevelt was elected came on in ever increasing numbers. For many years to come this growing shadow of the 1930's was to change the profession of medicine in America. The medical profession — a creative, human, understanding, self directing group riding on scientific facts — was to find itself beset on all sides.

The doctor became subject to third party direction. If the government paid or insurance paid, then the patient and his doctor became subject to outside control. Benefit accrued but the doctor became less a professional and found himself more in business. He became part of a Health Care Delivery System. He became a Health Care Provider and the patient became a Consumer.

Documentation rather than diagnosis and understanding became the rule. The doctor in charge disappeared and the primary physician, the secondary physician and even the tertiary physician came to take his place.

Consumers demanded consumer rights and these grew as fast as medical costs rose. Costs and values collided; controls, stipulations and regulations overruled medical values. As professional activity diminished, business or government activity increased. The bottom line of business is profit, the dollar. An outgrowth of the social programs has made outside control and the search for the dollar the hallmark of the setting in which the profession of medicine is practiced.

This third shadow, which began its pervasive influence with the first welfare program of the 1930's grew and grew until it affected the doctor in a profound and lasting way. For the doctor this third shadow has changed the circumstance and feelings of the time, the milieu in which he works, and it dictates the way he lives, thinks and practices medicine in South Florida, in Miami.

*"As old and as new
As the ills of man
The art lives
Yours; but to clothe it for to-day"*

F.H.S.
D.C.M.A. Bulletin

- Dr. Stewart; 3661 South Miami Avenue, Miami 33133.

Fort Dallas, a most salubrious post

William M. Straight, M.D.

On Tuesday, February 13, 1838, Lieutenant Levin M. Powell, USN with 160 men of the Navy and Captain W.B. Webster, USA with 39 men of Company C. 1st Artillery, embarked on a small steamer at Key Biscayne and headed for the mouth of the Miami River. Their mission was to reconnoiter and select a site for a military outpost from which to carry out forays against the Seminole Indians.¹

At this time the Second Seminole War was into its third year and peace was not in sight. An undetermined number of Indians were ranging over south Florida plundering settlements and murdering settlers. It was also known that arms and supplies were being smuggled from Cuba to the Indians in south Florida. To protect the settlers and to stop this supply operation the Navy had stationed picket boats along the coast and the Army had established outposts at strategic points along the mainland.

If we had been one of that party almost a century and a half ago, what would we have seen amid the squawking of startled herons and egrets? The steamer would have chugged up the mangrove lined river perhaps 500 yards to the Fitzpatrick plantation landing on the north bank. Stepping ashore we would have seen ahead of us an extensive area which had once been cleared and cultivated but was now being reclaimed by the lush tropical vegetation. Here and there we would have seen sturdy pines, live oak trees, fruit trees such as orange and lime and coconut palms.

Had our eyes scanned both banks of the river we would have seen the remains of a log cabin, five frame houses, a kitchen, corn cribs and twelve slave cabins.¹ This was what remained of the 2500 acre Richard Fitzpatrick plantation which extended along both banks of the river. Two years prior, when the war erupted with the massacre of Major Francis Dade and his detachment, the plantation had been abandoned and soon thereafter it had been plundered and burned by the Seminoles.

North and east of where we stood we would have seen a thick tropical hammock of pidgeon plum, poison wood, white stopper, gumbo limbo, satin leaf and the like obscuring our view of Biscayne Bay. Projecting from the southern end of this hammock near the mouth of the river could be seen a mound that rose 20 or 25 feet and covered an area 75 feet wide and 100 feet long.² This mound was the legacy of the pre-Seminole Indians of southeast Florida, the Tequesta, whose principal village was at the mouth of the Miami River for perhaps a thousand years before the Spanish came.

After several hours spent in exploration of the immediate area, Powell and Webster selected a site perhaps 300 yards east and 100 yards north of the landing and the troops set to work building three blockhouses of pine logs.¹

Fort Dallas, so named after Commodore Alexander J. Dallas, commander of the West India Squadron, was occupied intermittently over the next 20 years. The first occupation was February and March 1838, after which it was abandoned until February 1839. The second occupation extended from February 20, 1839, through June 1839. The third occupation began October 1839, and continued through January 31, 1842. Even after the troops were withdrawn from

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Fort Dallas the Second Seminole War continued for another year. Finally, with many of the Seminoles having been transported to Oklahoma and the remainder having retreated into the most inaccessible parts of the Everglades, the Army gave up and ended the war by an Army Order on August 14, 1843.

During the Second Seminole War Fort Dallas was manned by an average of 100 men with six to eight officers. Among the officers were Assistant Surgeons J.H. Baldwin and James W. Russell, the one following the other. The men were kept busy with construction, housekeeping chores and forays into the Everglades in heavy canoes on seek and destroy missions against the Seminoles. Disease, chiefly the diarrheas, dysenteries and fevers, was rampant. Four deaths from disease were recorded during these 33 months: one of unspecified cause and one each of acute dysentery, phthisis pulmonalis (tuberculosis) and hydrothorax. Only two deaths from enemy action were recorded: Captain S.L. Russell, killed in an Indian ambush on the banks of the Miami River, February 28, 1839, and Private Allers of Co. H, 2nd Dragoons, wounded during the foray into the glades on which the Spanish Indian leader, Chekikee, was killed, and who died on December 11, 1840.

Although there is no description of the hospital at Fort Dallas at this time, there are repeated mentions of a hospital. The monthly reports of the sick and wounded usually note that two to seven men were "In Hospital," at the end of the month. Although the hospital could have been merely one or more tents, it is more likely it was a log building.

Peaceful interlude • With the declaration of the end of the Second Seminole War, settlers returned to the Biscayne Bay country. Fitzpatrick sold his ruined plantation to his nephew, William F. English, and English embarked on plans for a city near the Miami River mouth. Streets were platted on the south bank of the river and several lots were sold. The seat of Dade County was moved to English's budding city. A Doctor R.R. Fletcher built and operated a store and



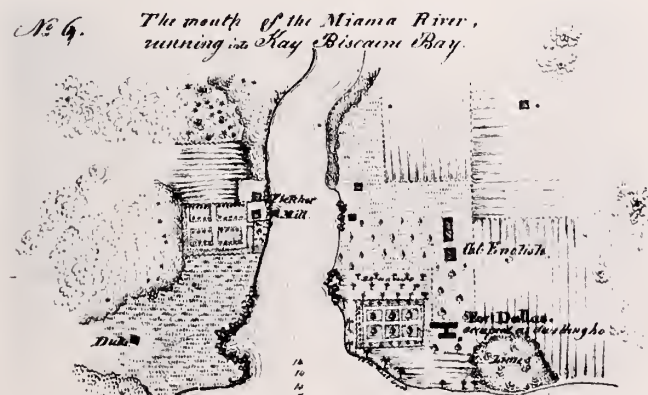
Fort Dallas at the Mouth of the Miami River, 1871. (Harper's Magazine, Vol. XLII, March 1871, p. 515.)

a starch mill³ on the south bank and further up the river on the north bank was another large mill.¹ At that time Dade County extended from below Indian Key to the mouth of the Saint Lucie River and west to Lake Okeechobee and had a population of about 150 souls.⁴

The phony war period • Then in July 1849, the word flashed through the frontier settlements that the Seminoles had struck again. Alarmed, the Biscayne Bay settlers flocked to the Cape Florida Lighthouse and from there to Key West. Washington reacted by sending Company F, 2nd Artillery to reoccupy Fort Dallas on September 9, 1849.¹ This occupation lasted 16 months during which there was very little action causing this episode to be dubbed by Dade County historian, Arva Parks, the "Phony War."

On arriving in 1849 the troops again found buildings in disrepair. However, the depredation this time was not of Seminole doing but that of local settlers who had stripped the vacant English plantation for building materials. The troops set to work replacing roofing, flooring, windows and doors in one of the two stone buildings, repairing existing log houses and building two new log houses near the Indian mound for the use of the officers. During this occupation the garrison averaged about 48 men and several officers. One medical officer, Assistant Surgeon J.L. Adkins, seems to have served during the entire occupation. He has left us a description of the fort at that time:

Fort Dallas is situated on a comparatively high bluff, near the mouth of the Miami River, and overlooking Key Biscayne Bay, a beautiful sheet of water separating the Post from the sea by about three miles distance — The soil is very light, and broken for the most part by limestone rock. The Pine barrens are composed of siliceous sand, vegetable and other matter. The Hammocks are the most productive of any portion of the coast. The Pomgranite, Fig, Orange, Lemon, Lime, Citron and other fruits are cultivated, blooming and bearing the year round...Frost rarely visits this locality, and as Spring is perennial, fruits, flowers and vegetables are always present...Everything seems combined to render this a healthy spot.⁵



Map by U.S. Coast Survey Team under Chief F.H. Gerdes Feb. 1849. (Natl. Arch. R.G. 23)

Indeed, it was a healthy spot during that occupation for only a single death is recorded in the 16 months of occupation, a case of phthisis pulmonalis. As all remained quiet and the settlers had long since returned to their farms, the troops were withdrawn in the last of December 1850, and Fort Dallas was again abandoned.

Another peaceful interlude • During the next four years life was humdrum in the Biscayne Bay settlement. Crops and groves were cultivated, quantities of coontie flour were prepared and shipped to northern markets, and the settlers fished and hunted for both food and sport. A few new people came but the occasional depredations of the Seminoles stealing out of the Everglades vastness kept the settlers uneasy and discouraged newcomers. The Army re-established Fort Dallas on January 3, 1855, for its final and longest continuous occupation.¹

Third Seminole War • The arriving troops found the situation much as it had been when the fort was reoccupied in September 1849: everything useful had been stripped from the standing buildings for the use of local residents. Again they set to work replacing roofs, flooring, doors, shutters and the like. They added a second story "of boards" to the larger of the two stone buildings. Mention is made⁶ of, "...a small frame building here, that was put up when the place was previously occupied as a Military Post — this is now used as a Hospital Dispensary &c — and I propose to make an addition to it so as to afford one or two wards for the Sick..." In the summer of 1856 this hospital was described as, "...containing two wards each 15' x 19', a Mess room 20' x 13', and a (separate) kitchen (one room) 10' x 12'. In good condition with exception of the Mess room which requires roofing."⁷ Across the front of the hospital was an eight foot wide piazza. This hospital accommodated ten or twelve patients and was likely constructed of squared logs and thatched with palmetto fronds. The palmetto fronds had to be gathered some distance from the fort, carried by hand a half mile and loaded on boats to be floated four miles down river to the fort.⁸ There is extant a request from Lt. Morris for 1000 lbs. of straw "for the Hospital." This suggests the use of straw for floor covering and mattress tickings. There is also a request for mosquito nets for the use of the hospital but no mention of screening for the doors and windows. Many other buildings were added and by March 1858, Fort Dallas was a sizable establishment.¹

During this occupation things were relatively quiet. The men were occupied in construction, house-keeping chores and Everglades forays seeking but seldom encountering the Seminoles. On one occasion, January 7, 1856, the Seminoles attacked the coontie mill of Peter Johnson in what is now Coconut Grove, 708 / J. FLORIDA M.A. / AUGUST 1982 / Vol, 69, No. 8

killing Johnson and his helper.¹ Other than that the Seminoles kept pretty much to themselves and eluded the soldiers.

The garrison averaged about 140 men and six to eight officers. Medical officers who served during this occupation were: Acting Assistant Surgeon Pascal A. Quinan and Assistant Surgeons Edward W. Johns, R.F. Simpson and Richard D. Lynde. The general health of the command was good but not so good as during the 1849-1850 occupation. In particular diarrheas and dysenteries were bad during most of 1855 and the last two quarters of 1856. Fevers were prevalent in the first quarter of 1858. In all, four deaths (three in the year 1855) occurred during the 41 months of occupation. These were attributed to four different causes: chronic abscess, enteritis, phthisis pulmonalis and drowning. The last of these occurred when a soldier delirious with fever, walked into the Miami River the night of January 17, 1858.

In May 1858, the troops were withdrawn for the last time and Fort Dallas permanently closed. This action must have caused sorrow to the local settlers who had profited not only economically from their presence but also socially. Many years later an elderly resident of Key West, who had lived in the Miami River community in 1855, described the "gay parties" they had at Fort Dallas at that time.

The Army surgeon • The Army surgeon of that day was likely to be several cuts above the usual civilian physician. The U.S. Army Medical Department regulations stipulated that an applicant had to have, "...obtained a diploma or certificate from some respectable medical school, college or society, or have passed the examination of the Army Medical Board."⁹ Although many complained that the requirements were too stringent, Surgeon General Thomas Lawson held to these standards tenaciously. All but one of the medical officers who served at Fort Dallas were Assistant Surgeons. This rank entitled them to the pay and allowances of a First Lieutenant for their first five years and to those of a Captain thereafter. One medical officer, Pascal A. Quinan, was an Acting Assistant Surgeon. This indicates that he was a civilian physician hired by the Army for service at this specific post and for a specified period of time, a Contract Surgeon. His salary could not exceed 100 dollars a month and he was not entitled to any allowances or emoluments.

No mention is made of ancillary personnel for the hospitals at Fort Dallas, but it is likely the medical officer had to recruit his cook, housekeeper and nurses from among his convalescent patients. Larger posts during the Seminole War period might have been allowed a hospital steward, but Fort Dallas was too small for this.

Supplies and equipment • The surgeon apparently had available adequate supplies of drugs,

dressings and surgical instruments. However, diagnostic instruments were few. For example, although the stethoscope was in use at that time, it was not on the Army supply table. Thermometers were part of the issued equipment but these were meteorological thermometers, not clinical thermometers. In addition to his duties of caring for the sick and wounded and the camp sanitation, the medical officer was expected to keep a log of temperature, rainfall and wind changes. For diagnosis the surgeon depended upon the patient's medical history, physical findings and the character of the body discharges. The discharges were, of course, examined only with the naked eye for the microscope as a tool for clinical diagnosis was still half a century away.

Disease vs Bullets • As in all wars, disease caused far more disability and death than did bullets. Earlier in this paper we have made general comments about the sickly periods of Fort Dallas, now let us look at the more common diseases in detail.

What might today be nicknamed "Osceola's Revenge," the diarrheas and dysenteries, were by far the most common diseases encountered. In that day before the use of the clinical microscope, culture media and bacterial staining, only rarely could a specific causative agent be identified. Diarrhea was characterized by frequent loose stools with little pain and debility and no fever. Dysentery was a febrile disease with loose stools, rectal pain and stools containing blood and mucous. Diarrheas might progress to become dysenteries as Assistant Surgeon Johns stated occurred frequently at Fort Dallas. Whereas diarrheas were a nuisance, dysenteries might result in death.

Diarrhea and dysentery were both thought due to long continued heat and atmospheric moisture. Surgeon Johns also mentions as a possible causative factor the Army diet of salt rations with few fresh vegetables.^{10 11} Johns may have been partially correct for the Army diet of that day supplied only one-third of the daily requirement of niacin. Pellagra, which is due to niacin deficiency and which may manifest with diarrhea, may have been present. Johns also cited another possible factor, "the abundant supply of bad liquor."¹⁰ Still another Fort Dallas surgeon thought the heavy lime content of the water the soldiers had to drink induced diarrhea.¹²

The treatment of diarrheas seems to have been relatively easy. Quinan reports,¹² the diarrheas yielded, "...readily to gentle purgation followed in due time with the exhibition of Opium combined with Acetate of Lead, occasionally a mercurial is found useful, whilst diet and the horizontal position are found necessary aids."

Dysentery was quite another matter and accounted for two of the deaths at Fort Dallas and seven deaths at Fort Russell, across the bay on Key Biscayne.^{13 1} One of these was the death of Private

Patrick Hickey, 2nd Infantry, on August 11, 1840. The report of this case illustrates the therapy of dysentery then in vogue:

Patrick Hickey was seized with Diarrhoea on the 6th August, was ordered 01. Ricini [castor oil] ounces one after the action of which he took Pulvis Doveri [ipecac, opium and potassium sulfate] Grains V morning and evening [this would supply 1/2 grain of opium with each dose]...on the 10th...I perceived a great change. He complained of great irritability of the Stomack. A large blister was applied to the Abdomen and Pulvis Doveri Grains V with Calomel Grains I administered every hour until a short period previous to his decease, without producing the desired effect. Prior to the application of the Blister, cupping had been used to the Abdomen.¹⁴

Other therapies in use were blood letting, rectal infusions of opiates, oral astringents such as silver nitrate and copper sulfate, and at times, iron (ferrous sulfate) and quinine.

The ague and other fevers • Almost as common at Fort Dallas as the fluxes were the ague and other fevers. Fever at that time was considered a disease in itself rather than a sign of disease as we consider it today. The fevers were commonly divided into remittent, intermittent and continuous. Ague was another name for the intermittent fevers. There were still other designations less commonly used such as: simple, bilious and congestive fevers.

Remittent fevers were characterized by daily fever spikes and periods of lower temperatures during the 24 hours but at no time did the temperature reach normal. Today many entities would fall into this category such as: pneumonia, rheumatic fever, endocarditis, tuberculosis and certain tumors. Intermittent fevers were characterized by fever spikes separated by completely fever free periods. These would be called the malarias today but in the days of Fort Dallas the term malaria applied to districts where fevers were common, and of course, the malaria parasites were yet to be discovered. Intermittent fevers were further divided into tertian (two fever spikes in three days with a fever free day between) and quotidian (a daily fever spike with most of the 24 hours free of fever). We still use the term tertian in the manner they did and apply it to malaria caused by the *Plasmodium vivax* or the *Plasmodium ovale*. What was then designated quotidian would possibly be malaria due to *Plasmodium falciparum*, and we have a third type we call quartan malaria (fever spike every third day) due to the *Plasmodium malariae*.

Regardless of type, fever was thought to be due to noxious emanations from swamps, marshes and jungles. Land freshly cleared was thought particularly likely to cause fevers. It was thought that the sun striking the previously shaded humus released pent-up noxious miasmas. Certain fevers such as the bilious remittent fever (known as yellow fever today) were thought spread by, "...a diffuse and impalpable effluvium or vapor emanating from the

secretions, excretions and surface of persons already affected."¹⁵

More than one of the medical officers at Fort Dallas commented that the climate was so salubrious that only "imported" fevers were seen. Nonetheless, fevers were particularly bad at Fort Dallas in the summer of 1841 and the winter of 1858. Fevers seem to have been even more prevalent at Fort Russell especially during the last two quarters of the years 1840 and 1841 and the winter of 1842. For example, during the last quarter of 1841 there were 119 cases of fever among a garrison of about 175 men and officers at Fort Russell.

From all reports, the mosquitoes were fierce in those days. Master Edward C. Anderson, USN who visited the Miami River community in May 1844, remarked, "I have never in all my travels met with such an immense (sic) number of horseflies & other insects as are to be found here...When the United States troops were stationed here I have been told that the sentinels were posted under musquito (sic) bars."¹⁶ Although we cannot be certain that the anopheles mosquito, the carrier of the malaria parasite, was among that "immense number," it seems likely that it was.

What may be the first autopsy performed within the present limits of Dade County was performed by Assistant Surgeon Benjamin W. Woods at Fort Russell on May 3, 1842. The body was that of Private William Fays, 2nd Infantry, who died of congestive fever.¹⁷ From the report of this autopsy which included the opening of the skull, it seems likely that Fays died of pneumonia complicated by a meningitis.

Whatever the cause of the fever, the sovereign remedy was "quinia" (quinine). By the outbreak of the Second Seminole War purified Sulphate of Quinia was available to the troops in the field. It was commonly given in four to six grain doses every hour beginning four to six hours prior to the next expected fever paroxysm. At times as much as 300 grains (18 grams) of quinine were given in 24 hours. As the currently recommended total daily dose of quinine is two grams,¹⁸ it is not surprising that one medical officer reported the patients uniformly complained of "...ringing and buzzing in the ears, a sense of stricture across the forehead and temporary deafness (toxic symptoms of quinine)."¹⁹

Assistant Surgeon J.L. Adkins⁵ details his treatment of the First Lieutenant of the Company who became ill with remittent fever shortly after returning from "...an excursion of a few days down the coast." He states:

A sedative medication with a mercurial like the following was relied on:

Rx Hydrarg. Chl. mitis	1/2 drachm
Ant. and Pot. tart.	
Pulv. opii aa	1/2 ounce

given one powder every three hours. This, aided by warm

bedding and cold sponging of the body, and the cold douche upon the head, induced full diaphoresis by the end of the third day...The bowels were kept open by half a drachm of Pulvis Jalapa comp. or a Sedlitz powder (potassium tartrate, sodium tartrate, bicarbonate of soda and tartaric acid)...At the proper moment (on the first appearance of remission) Sulphate of Quinia was given in a single dose of 16 grs. (almost one gram) and there was no return of fever. Patient was much debilitated and reduced, but an improved diet with returning appetite and Sulphate of Quinia in tonic doses — 2 grains daily for one week restored him to health...

Vitamin deficiency diseases • The vitamin deficiency diseases, scurvy and night-blindness,²⁰ were rather frequent diagnoses on the sick reports. In this land where "...Spring is perennial, fruits, flowers and vegetables are always present...," it seems odd that vitamin deficiencies would be seen.

Sixteen cases of scurvy were reported on the sick reports from Fort Dallas during the Third Seminole War. All of these were apparently "imported". Thus Assistant Surgeon Thomas A. McPalin, who marched with five companies from Fort McRae on the eastern shore of Lake Okeechobee (near the present Port Mayaca) to Fort Dallas in the winter of 1857, mentions, "A grove of wild oranges on the southwest side of the Miami cured for me several incipient cases of scurvy, and gave me (with the hospital conveniences under Dr. Simpson's charge) much assistance in treatment during my stay"²¹ The Army diet of that day supplied only two-thirds of the daily requirement of vitamin C and that only if 200 grams of potatoes were eaten daily. Potatoes were often not available and thus, since the body uses up its vitamin C stores in two to four weeks, it is quite reasonable that scurvy appeared on long marches. It was known that scurvy was the result of a diet deficient in fresh fruits and vegetables but the discovery of vitamin C did not occur until 1932.

The association of nightblindness and diet was not recognized in Seminole War days. Indeed, night-blindness was thought due to, "...an exhaustion of the power of the retina in consequence of exposure to strong light during the day..."²² The soldier's diet of that time supplied negligible amounts of vitamin A, the deficiency of which we now know as the cause of nightblindness. Furthermore, the diarrheas and dysenteries depleted what stores of vitamin A were in a soldier's body thereby augmenting the deficient diet in producing the disease. The usual treatment of nightblindness was, "...confinement to a dark room, use of emetics and cathartics, and the application of cups and blisters to the temples and nape of the neck."²² If these measures failed, salivation (probably with calomel), green shades before the eyes and, as a final resort, removal to "ones native clime" might be tried.

Other diseases that appear on the reports of the sick and wounded are: dermatologic problems such as eruptions, boils ("phlegmons"), and lichens; respiratory

diseases such as catarrh, tonsillitis, otitis, bronchitis and pneumonia; rheumatism; syphilis; gonorrhea; tuberculosis, both pulmonary (phthisis pulmonalis) and glandular (scrofula); ophthalmia and sunburn (coupe de soleil).

Demon rum • As was true at many of the Army posts during the Seminole Wars, drunkenness was a problem at Fort Dallas. Until 1838, the year that Fort Dallas was established, the Army had a "spirit ration" of one-half pint of whiskey or rum daily for each man. In 1838 coffee and sugar were substituted for the spirit ration, a move that wasn't popular with the men but was designed to reduce the drunkenness and the altercations that resulted from the liberal supply of alcohol. However, when the Army ceased dispensing whiskey, the sutlers quickly stepped into the breach and made handsome profits selling cheap whiskey at dear prices. Near Fort Dallas were Fletcher's store on the south bank of the river and Captain Sinclair's sutlery on the north bank.¹ Admissions to the sick list for drunkenness and delirium tremens appear from time to time, particularly during the final occupation of Fort Dallas when the garrison was relatively large and the activities of war at a minimum. Thus in the first quarter of 1858, three cases of delirium tremens are recorded. One death was attributed to intemperance at Fort Russell, July 11, 1841.

Wounds • Most of the wounds recorded by the medical officers were accidental and of minor consequence. Puncture wounds were common and attributed to such things as stepping on fish spines. Incised wounds were commonly caused by stepping on sharp sea shells. Acting Assistant Surgeon Pascal A. Quinan¹² notes that several soldiers suffered incised wounds while squaring timbers with a broadaxe for the construction of buildings. Most of the several gunshot wounds recorded were from the accidental discharge of firearms. As previously mentioned, one officer died near Fort Dallas of gunshot wounds inflicted in an ambush by Seminoles, and one soldier was wounded by enemy fire during a foray into the Everglades.

Major surgery at Fort Dallas • There are several mentions of minor surgery performed at Fort Dallas but only a single mention of major surgery, the amputation of a leg. In February 1841, Assistant Surgeon J.W. Russell reported that a soldier named Bradley had received a charge of "small shot" in his ankle from a distance of only a yard or two. This severed the anterior tibial artery and shattered the bones of the ankle and foot. Russell dressed the wound with a "very dilute solution of Kreosote" and possibly other medications until mid-August when, "...extensive caries of the bones of the foot and ankle" had developed and:

...it was deemed necessary to sacrifice the limb in order to save his life. The operation was performed on the 14th inst. four inches below the knee. It united throughout by first intention, the ligatures have come away & he is now nearly well & his general health and strength improving rapidly.²³

Anesthesia • In his report upon the amputation of Bradley's leg Russell makes no mention of the use of anesthesia. It is likely Bradley received oral morphine in the form of laudanum (tincture of opium) and a belt of whiskey or rum. Ether anesthesia was yet to be discovered. The first use of an anesthetic was the use of ether during a tooth extraction by a dentist in New York state in January 1842. Unaware of this, a Georgia surgeon used ether to remove a skin tumor in March 1842. In October 1846, the first public demonstration of ether anesthesia occurred in Boston. Chloroform anesthesia was first introduced in Scotland in November 1847.²⁴

What may be the first use of ether anesthesia in Florida occurred at Fort Dallas in May 1850. Ether or aether, as it was then spelled, was on the Army supply table for oral use in the treatment of lung diseases at the time of the First Seminole War, 1818. In his Quarterly Report of the Sick and Wounded at Fort Dallas for the Quarter Ending June 30th, 1850, Assistant Surgeon J.L. Adkins tells us of the removal of a large fishhook from the hand of a soldier.

...the wound was caused by a large fishhook passing nearly through the thumb near the articulation of the phalanges. It was cut down upon and drawn through with forceps in the line of entrance. The operation though simple, would have caused much pain, but for the inhalation of Aether, which rendered the patient insensible to pain, though not entirely unconscious of the proceedings.

From Adkin's report in December 1850, we learn the wound was dressed with cold water dressings in the hope that it would heal by first intention, however it suppurated and warm poultices were applied to achieve healing.

In these early days of the use of anesthesia the top brass in the Surgeon General's Office were slow to adopt this new idea. Indeed, there were some who as late as the Civil War insisted that experiencing the pain of surgery was necessary to mobilize the body's defenses sufficiently to permit recovery from the surgery.

The summing up • Fort Dallas and Fort Russell were relatively healthy spots when compared to other Seminole War posts. Thirteen deaths in 81 months of occupation were recorded at Fort Dallas and 17 deaths in 36 months of occupation at Fort Russell. Reporting upon the condition of Fort Dallas in December 1850, Assistant Surgeon J.L. Adkins sums it up:

Too much cannot be said of the salubrity of the place which the troops are about leaving. Badly fed and poorly clad for months past mainly in consequence of being so cut off from

all communication, the soldiers at any other place would have suffered much it is probable, and much sickness might have prevailed. But all things considered, there has been in this respect a remarkable exemption here.⁵

Footnotes and References

1. The author is indebted to Mrs. Arva Moore Parks for the history of Fort Dallas and the Miami River community. The references cited are from her unpublished manuscript on *The Fort Dallas Historic Site*, but most of this information will also be found in: *The Magic City - Miami, Tulsa, Oklahoma*, Continental Heritage Press, Inc. 1981.
2. Sewell, John: John Sewell's Memoirs and History of Miami, Florida, Vol. I, privately printed, 1933, pp. 43-47.
3. Perhaps the largest of the early Dade County industries was the manufacture of a flour or starch from a tuberous plant, a cycad of the genus *Zamia*. The product is variously referred to as arrowroot, coontie, koontie and comptie starch. It was used by the Indians and settlers to make bread and was shipped to northern markets for use as a flour.
4. Hudson, F.M.: Beginnings in Dade County, *Tequesta*, 1:1-35, July 1943.
5. Adkins, J.L.: Quarterly Report of the Sick and Wounded, Fort Dallas, Florida, for the Quarter Ending March 31, 1850. R.G. 94, Records of the Adjutant General's Office, 1780's to 1917, National Archives and Records Service, Washington, D.C. Hereinafter these reports, all of which are to be found in Record Group 94 at the National Archives, will be designated as: "S & W Rpt." with a notation of "Monthly" or "Quarterly" whichever applies.
6. Letter: Capt. B.H. Hill to Maj. Genl. T.S. Jesup, Fort Dallas, Florida, 15 Feby. 1855, R.G. 92, National Archives and Records Service, Washington, D.C.
7. Letter: 2nd Lieut. William Graham to Maj. Genl. Thos. S. Jesup, 30 June 1856; and a typescript in Book 37, M.406, Fort Dallas file, National Archives and Records Service, Washington, D.C.
8. Letter: Lieut. Louis Morris to Maj. Genl. Thos. S. Jesup, Jan. 11, 1855, R.G. 92, National Archives and Records Service, Washington, D.C.
9. General Regulations for the Army or Military Institutes, Washington, Printed by Davis and Force, 1825, Paragraph #1257.
10. Johns, E.W.: Quarterly S. & W. Rpt. Fort Dallas, June 30, 1855.
11. From the accounts of the farms and plantations in the Biscayne Bay settlement, it is hard to understand why there would be a lack of fresh vegetables. Perhaps there were too few settlers to supply the needs of the post and the soldiers made no attempt to farm for themselves.
12. Quinan, P.A.: Quart. S. & W. Rpt., Fort Dallas, March 31, 1855.
13. Although this narrative is primarily about Fort Dallas, from time to time mention will be made of the medical problems at Fort Russell on Key Biscayne. This was an encampment near the southern end of Key Biscayne from April 2, 1838, until June 1842. Initially it was known as Fort Bankhead after its first commander, Lieutenant Colonel James Bankhead. After the death of Captain S.L. Russell in an Indian ambush, February 28, 1839, it was renamed in his honor.
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● Dr. Straight, 550 Brickell Avenue, Miami 33131.

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FLORIDA MEDICAL DEPARTMENTS

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NOTES & NEWS

Drs. Hodes & Brickler honored by family physicians

Richard S. Hodes, M.D., of Tampa, and Alexander D. Brickler, M.D., of Tallahassee, were honored at the Florida Academy of Family Physicians' 33rd Annual Scientific Assembly.

Dr. Hodes, a Past President of the Florida Medical Association and current Chairman of the Department of Anesthesiology at the University of South Florida College of Medicine, received the Academy's 1982 Freedom Heritage Award. He was cited for his 15 years as a member of the Florida House of Representatives and his leadership in the maintenance of an outstanding health care system in Florida.

Among other things, Dr. Hodes was the author of the Community Hospital Education Act, which promoted the training of primary care physicians in Florida community hospitals.

Dr. Brickler was named by the Academy as "1982 Florida Family Physician." He began his family practice in Tallahassee in 1957 after graduation from Howard University and Meharry Medical College.

Dr. Brickler is a Past President of the Capital Medical Society and once served as Chairman of the Executive Committee of Tallahassee Memorial Regional Medical Center.

JCAH surveys announced

The Joint Commission on Accreditation of Hospitals has announced that five hospitals in Florida are scheduled for survey from July through September. They are identified as: North Ridge General Hospital, Fort Lauderdale; Bayonet Point Regional Medical Center, Hudson; Methodist Hospital, Jacksonville; West Pasco Hospital, New Port Richey; and St. Petersburg General Hospital, St. Petersburg.

Dade physician honored

Francisco Hernandez, M.D., of Miami, has been named the fourth recipient of the Dade County Medical Association's "Physician's Recognition Award For Service to the Citizens of Dade County." Previous winners have included Jean Jones Perdue, M.D., Charles F. Tate Jr., M.D. and Rose E. London, M.D.

Dr. Louis Sales honored

A lectureship has been established in Jacksonville in honor of Louis M. Sales, M.D., a well-known rheumatologist and Past President of the Florida Society of Rheumatology.

The Louis M. Sales Lectureship was created by the directors of the Northeast Florida Arthritis and Connective Tissue Disease Diagnostic Center. The lectureship will bring an expert in rheumatoid diseases to Jacksonville on an annual basis to address city physicians.

Dr. Sales was cited among other things for his leadership in providing arthritis patients in Jacksonville and vicinity with care and treatment of the highest quality.

UM resident appointed

Linda A. Marraccini, M.D. of Miami, a resident physician at the University of Miami/Jackson Memorial Center, has been appointed to a four-year term on the National Board of Medical Examiners. She was named to the post as a representative of the American Medical Association's Resident Physician Section.

DEAN'S MESSAGE

Planning for our academic health center.

Two years have passed since the 1979-80 status report for the University of South Florida College of Medicine and many anticipated events have been successfully completed. Two areas of particular note are faculty development and facilities planning.

Outstanding faculty members in many departments have been recruited from prestigious institutions around the nation. Only one departmental chair

is vacant at this time, that being in the newly created Department of Orthopaedic Surgery. Recently appointed chairpersons are:

Department of Family Medicine — Charles E. Aucremann

Department of Radiology — Martin L. Silbiger

Department of Pathology — David T. Rowlands, Jr.

Department of Surgery — Richard G. Connor

Department of Anesthesiology — Richard S. Hodes

Facilities planning with an eye toward development of on-campus clinical facilities has experienced rapid progress. During the 1982 legislative session, the legislature approved and funded a 162 bed Cancer and Chronic Disease Research and Treatment Center. Ground-breaking will occur in late 1982 and opening is anticipated during early calendar year 1985. The facility will be on the campus of the College of Medicine and is intended to provide comprehensive tertiary care to cancer patients including the latest diagnostic and treatment modalities. A significant portion of space will be dedicated to research facilities which will complement ongoing endeavors and supplement the current oncology program. The facility will be the site of clinical teaching for medical students, resident physicians and fellows in various oncology fellowships.

The Southwest Florida Blood Bank is constructing a major branch facility directly across from the College of Medicine. The Blood Bank serves many hospital needs and is affiliated with the Department of Pathology. Here, too, space will be dedicated to research and will serve as a site for collaboration between the College of Medicine and the Blood Bank on many projects. This facility will also be the home of a pathology fellowship in "blood-banking" medicine.

The Shrine International has chosen the campus of the College of Medicine as the site of its twenty-first hospital facility. The Groundbreaking Ceremony took place on June 12, 1982. Anticipated opening is December 1983. This Crippled Children's Hospital will have 60 beds and will be closely affiliated with the College of Medicine. Medical students and selected resident physicians will participate in clinical learning experiences in this facility. Here, too, research will be a significant theme with support provided by Shrine funding.

The 1982 legislative session also granted a program in Public Health and planning funds for a School of Public Health. This will add another health care school to the Medical Center and provide a needed resource for public health education to the State of Florida.

Development of these facilities is progressing well and should result ultimately in a major Academic Health Center on the campus of the University of South Florida.

The College of Medicine has had a pleasant experience in the transition to the four-year curriculum which has been well received by students and faculty alike. The College will undergo a scheduled LCME accreditation site visit in January 1983.

The College of Medicine is grateful for the support which it has received and is looking forward to completion of the various projects outlined above.

*Andor Szentivanyi, M.D.
Dean of the College of Medicine
University of South Florida
Tampa*



WORTH REPEATING

Medical Leadership

Today I am to be a teller of tales. I will relate to you the interesting story of Abel Seymour Baldwin, M.D., founder of organized medicine in Florida.

A perusal of many fine presidential addresses delivered over the years reveals that most of the Presidents of the Florida Medical Association related activities which were carried out during their administration. Many addresses were filled with platitudes and some involved downright "preaching." During my 15 years as an officer of this Association I have related innumerable accounts of our activities, I have organized and participated in numerous projects, I have recanted my share of platitudes, and I am sure you will agree I have done more than my share of "preaching." Faced with the dilemma of "repeating repetition" I searched for something different. I am grateful to my friend, Dr. Dekle Taylor, for suggesting that I look to history for a subject that might be timely as well as interesting.

On accepting this suggestion, I found it was not long before my gratitude was in evidence again. This time it was extended wholeheartedly to the late Dr. Webster Merritt for writing his two fine books, "The Duval County Medical Society 1853-1953,"¹ and "A Century of Medicine in Jacksonville and Duval County."² Without these volumes it would be virtually impossible for a President of the Association to prepare an historical manuscript on medical history in Florida during his busy year in office. The latter book, which unfortunately is no longer available, relates the history of our Association so well that it is not only easy but it is a pleasure to take the historical trail.

I am happy to report to you that we again have an active historian, Dr. William M. Straight, serving as our archivist and delving into the background of Florida Medicine. Let us remember that the value of an historian is not fully appreciated until his history alone remains to portray the story of the times. Let us help Dr. Straight and our other archivists in every way possible. Incidentally, our office badly needs the photograph of Dr. J.W. Hicks, of Orlando, the thirteenth President of this Association in 1887. Please become historical sleuths long enough to find us that picture. It is all we lack for a complete panel of Past Presidents.

These are fabulous times in which we live, with the Atomic Age and the Space Age. The Medical Era, however, extends through both these ages and is just as fabulous in its advances as are the miracles of atoms and space. Lest we forget, these marvelous advances were made possible by the sound foundation in facts which were laid by our forebears, men and women of integrity who worked hard under trying circumstances to improve the health, welfare and knowledge of their fellow men.

Abel Seymour Baldwin, M.D.•In reading the history of Florida Medicine one is inspired by the intelligence, the ingenuity, the versatility and the leadership exhibited by one particular Florida physician over a period of 60 years. Perhaps "The Book of Jacksonville, A History (1895)"³ by S. Paul Brown illustrates it best in its opening biographical sketch which states:

Perhaps the most picturesque and interesting living figure in the history of Jacksonville is Dr. A.S. Baldwin. Several persons are now living who were in Jacksonville when he came here, in 1838, at the age of twenty-seven years. Fewer still were old enough at that time to even remember, much less participate with him, in any of the stirring events of that period in which he had a conspicuous part as one of the defenders of the State, in the Seminole War, then raging. His history from the time he came here, is the history of Jacksonville, for he has been prominently identified with every movement for the development and advancement of the City from its very inception almost, and now, at the ripe age of eighty-four, he may look back with pride and pleasure to his early struggles, and view with satisfaction the evidences all around him of their results.

Abel Seymour Baldwin was born in Oswego County, New York, March 19, 1811, being descended from old English families of Seymour and Baldwin. Orphaned in infancy, he was adopted by an uncle and aunt in nearby Madison County where he was taught by private tutors until he attended the seminary at Cazenovia and the Polytechnique Institute at Chittenango. His plans to enter an eastern college were frustrated by the death of his uncle in 1830; so he entered Geneva, now Hobart, College. He was graduated four years later with Bachelor of Science and Bachelor of Arts degrees. He was proficient in several branches of natural science, but chose to

study medicine in the office of Dr. Thomas Spencer, a professor in the medical department of his alma mater. He interrupted his medical studies after two years to accept the appointment of botanist in the geological survey of Michigan. Exposure to outdoor life in the severe climate resulted in "an acute attack of inflammatory rheumatism" which made it impossible for him to continue his work. He returned to New York, resumed his studies and in 1838 received the degrees of Master of Arts and Doctor of Medicine from Geneva College. He entered the practice of his profession in Geneva. In June of the same year he married Miss Eliza Scott, of an influential Geneva family. Owing to frequent recurrence of rheumatic attacks he decided to move to Florida, where he arrived December 2, 1838.^{2,4}

Diversity of Interests •Settling in Jacksonville, a straggling village of scarcely 1,000 inhabitants, Abel Baldwin entered upon the practice of medicine, which became at once extensive, remunerative, and very laborious. For some time he was the only physician within an area of 20 miles around Jacksonville.⁵ It soon became apparent that this young doctor was studious, scientific and practical, and I may add, persistent. It has been said that had this man gone elsewhere, the history of our state, and particularly Duval County, may have been quite different. Because of his training in botany he was well versed in the life and growth of plants. He was talented in art and music, did fine carvings on ivory and wood and played several musical instruments. He became an active member of the St. Johns Episcopal Church and for many years led its choir and played the viola. He was a warden of the vestry of that church for 56 years and helped in forming five other parishes from the mother church.^{2,4}

Dr. Baldwin's interest in botany and physical sciences was soon manifest by his keeping of daily thermometer and weather readings, so as to make a study of the climate which had restored him to health. These were begun in 1839. He became the official meteorologist for the Smithsonian Institute and in later years his records became, in large part, the basis for studies on the climatology of Florida. As a true scientist, he waited for his data to accumulate, he drew his conclusions and he worked vigorously to disseminate the knowledge he had obtained. His presidential address before the Florida Medical Association in 1874 was entitled "The Climatology of Florida."⁶ This represented the first detailed analysis of the Florida climate. Similar publications followed in *Semitropical*^{7,8} and other periodicals, constantly boosting the climate of Florida in a way that would make our present Chamber of Commerce proud.

Apparently word had come from other areas that the Florida climate was unhealthful, and one of the principle objections had been the excessive humidity

of Florida. Dr. Baldwin went to great lengths to expound the value of humidity in maintaining a comfortable temperature, pointing out that because of the humidity the differences in the highest and lowest temperatures recorded by him in 36 years in Florida were not so great as the diurnal differences in many places where very dry atmosphere existed. In true Chamber of Commerce fashion, the good doctor said:

There are few extensive marshes in this state, at the sources of the rivers, on the summit, are often found savannahs...This is a peculiar area in Florida and the residents around these savannahs are not especially liable to disease of the malarial character. The large area at the lower end of the peninsula, called the Everglades, and covered by water, is by many supposed to be marshy; but such is not the fact, for it is simply a shallow lake elevated above the ocean some 10 feet or more, surrounded by a rocky rim with a sandy and rocky bottom, containing clear, fresh water, which is discharged through the fissures or apertures in the rocky rim into Key Biscayne Bay and probably through the outlets on the West Side to the Gulf.⁶

He pointed out that the numerous rivers and lakes, the surrounding ocean and gulf, modified and equalized the temperature, rendering the country around their borders peculiarly adapted to the culture of oranges and other tropical fruits, while at the same time the residents in general enjoyed good health both summer and winter. He published mean temperatures and the rainfall from 24 stations scattered over Florida. It may be said that the good doctor was one of the first tourist and immigration promoters in Florida. As a result of his publications people began to come to Florida for their health and they returned home to spread the word far and wide. One of Dr. Baldwin's addresses on climatology brought condemnation from the editor of the *Philadelphia Medical and Surgical Reporter*, who stated that it was a "bid for the invalid."⁹ He particularly resented the statement that Florida had a special exemption from atmospheric commotion. The editor stated:

Evidently our southern friend thinks that pure air is only served up in Florida, and the same of water. The productions of the soil are so varied as to please or respond to the palatial caprices of all. The author detects nothing unfavorable about his state, but a few habits that are unfashionable. Our 'patent medicine' vendor and his wares levy too much on the purses of his neighbors. The error of the pamphlet is the unmitigated conceit of the writer about the advantages of his home.

It is significant that the Semitropical defended Dr. Baldwin in this manner:

Dr. Baldwin is perhaps as far from the characteristics ascribed to him as any man alive...His address is based upon careful scientific investigation and the observation and experience of thirty years...He does not vaunt mere opinion but gives the elements and facts from which an intelligent and dispassionate mind may arrive at definite and reliable conclusions.

Manifesting this interest further, Dr. Baldwin was active in the organization of the Florida International Chamber of Commerce and Mississippi Valley Society. In 1877, as secretary of the organization, he read an essay, "on transportation through the interior of the peninsular portion of the state, showing its inseparable connection with the proper system or plan of drainage and the reclamation of various tracts of submerged or overflowed lands in the southern portion of the peninsula, and that by such a system, properly planned and executed, both reclamation of various areas of the most fertile land in the state and cheap and convenient avenues of transportation through the interior could be effected." He was an indefatigable worker for a ship canal through Florida and for reclamation drainage projects in the interior of our state.¹⁰⁻¹¹

Scourges of the times • Abel Baldwin lived during an active medical period. Ephraim McDowell had already performed his surgical feats. Pasteur, Lister, Long and others were contemporaries,¹² but news of their feats was slow to travel and acceptance of their conclusions was even slower. Successful therapy of malaria with quinine was proposed by another Floridian, Dr. Henry Perrine,¹³ prior to Baldwin's early days in Florida, but malaria was still a problem. Yellow fever and smallpox were scourges that came in epidemics and caused great morbidity and mortality. In 1853 and 1854, scarlet fever and smallpox epidemics and a disastrous fire struck Jacksonville. Dr. Baldwin survived two epidemics of yellow fever in 1857 and 1888. He lost his wife Eliza in the 1857 epidemic and his only son Dr. William L. Baldwin, age 49, in the epidemic of 1888.^{3,4,14}

In 1877, Fernandina experienced a severe yellow fever epidemic. Since the cause of the disease was not known, the most satisfactory treatment of yellow fever consisted of good nursing and sanitary conditions. During the yellow fever epidemic in Fernandina in 1877, Jacksonville was accused of having unhealthy conditions and covering up its mortality figures. In August, Dr. Baldwin, as chairman of the health committee of the Jacksonville Board of Health, wrote to Dr. R.P. Daniel, then president of the Duval County Medical Society, denying unhealthy conditions existed in Jacksonville.² He directed attention to the excellent mortality statistics and asked that physicians knowing of facts to the contrary notify him. This action helped to calm the fears that existed at that time.

In 1883, much confusion existed because of a smallpox epidemic and the bad conditions of the pesthouse.² It was impossible to determine who had been vaccinated. Funds were not sufficient to improve conditions. Again Dr. Baldwin took the leadership on April 25, 1883, at the age of 72 years. He spearheaded a combined meeting of the Duval County

Medical Society and the Jacksonville Board of Health, recommended compulsory vaccination for everyone, vaccinated or unvaccinated, and volunteered services, free of charge, by members of the Duval County Medical Society in carrying out the vaccinations. These recommendations were passed by the society. This action activated the Board of County Commissioners; the pesthouse was cleared and the use of the Duval County Hospital and Asylum was assured for the care of suspected smallpox patients.

After the discovery of the ice machine by Dr. John Gorrie,¹⁵ another Floridian, physicians were groping for methods for preventing the spread of and for treating yellow fever. The concussion theory of Colonel Hardee proved ineffectual. The burning of tar and pitch flares at night were used extensively and may have been somewhat helpful by driving away mosquitoes. Dr. Baldwin proposed a method for "disinfecting exposed ships." He reasoned that the United States Government had in some instances sent infected vessels far northward so that disinfection was produced by the extreme cold. And the ending of epidemics with the first frost of the winter in the South caused him to conclude that, if germs there be, they were produced in hot climates and killed in cold. He, therefore, proposed an elaborate system of flexible pipes to be used on vessels at quarantine stations, to bring the temperature down several degrees below freezing inside the holds of the ships and keep it there for a time sufficient to destroy the germs of the disease.¹⁶ No records indicate that this recommendation received recognition other than its publication.

The Baldwin operation • Another of Dr. Baldwin's clinical proposals was more successful. In 1848, he carried out what was at least new to him in the treatment of intussusception of the bowel.⁴ It consisted of distending the lower bowel by tepid water administered gradually and persistently by pump, until the invaginated portion was drawn out, and the bowel put in condition for free discharge. Dr. Baldwin related:

The patient on which it was first tried happened to be present during my treatment of a case which terminated fatally, was also present at the postmortem examination, which showed me that if I had adopted this plan, in that case, the result might have been different. Being then called to this patient, and using the ordinary remedy for a day or so, I proposed to him this change of treatment, the operation to which I alluded, to which he consented, provided time to make his will in advance. This being accomplished, we proceeded at once to the injection of tepid water, which was carried until the abdomen was largely distended, pressure being made at the same time to prevent regurgitation. This plan was perfectly successful in this instance, and has been subsequently in every instance since, when tried and used sufficiently early in the complaint. This operation was adopted by my fellow physicians, who have named it the Baldwin operation since 1848.

A letter giving an account of this operation was published in the Medical Journal of Philadelphia edited by Hayes. Although Dr. Baldwin's name has long since been forgotten in relation to this procedure, it is essentially an accepted practice in the treatment of intussusception today and it is only in the last few decades that it has been revived and brought to popular use.

St. Johns Bar Project • During his professional visits up and down the St. Johns River, Dr. Baldwin observed the tides and currents which existed at its mouth where the St. Johns River and the Fort George Inlet entered the ocean only a short distance from each other.^{3,17} Dr. Baldwin spent considerable time studying these tides and formed strong opinions as to their causes. His original treatise on the subject, published in June 1876 and entitled "The St. Johns Bar," presents interesting and informative material. His knowledge of nature, of the hydraulic laws of rivers, tides, and currents, caused him to propose closure of the Fort George Inlet as the means of insuring an adequate channel for the St. Johns River. It was his opinion that as long as the crosscurrents existed between these streams, the shifting sands resulting from them were completely unpredictable and that Jacksonville could not be developed as a deep water port and the St. Johns River could not be adequately utilized.

Dr. Baldwin went to the citizens with his request at a public meeting. He was sent to Washington in 1853 to request appropriation of funds to carry out his proposal. The engineers of the Topographical Bureau accepted his proposals and he was successful in receiving two appropriations of \$10,000 each from the Congress. Unfortunately for him, the Army Engineers and not those of the Bureau were assigned to do the job. The Army Engineers did not accept the doctor's proposal and did considerable study of the problem, thereby spending the \$10,000 appropriation, much to Dr. Baldwin's disgust. The other \$10,000 was spent in similar manner over the doctor's protest. He was vehement in his condemnation of the Engineers who refused to try his recommendations, but suggested instead that a channel be dredged through the sand at the mouth of the river. Dr. Baldwin told them in no uncertain terms that the channel would be filled with sand by the time they completed the activity, and he recommended that appropriations be paid only for successful results, but an appropriation of \$25,000 was spent in dredging the channel. Dr. Baldwin's predictions were accurate in that no satisfactory channel existed by the time the dredging was completed.

Still, the Engineers refused to accept his recommendation of closing the Fort George Inlet. One of the Engineers, Lieutenant Wright, recommended a pier on the north bank of the river, but it was considered too expensive. Faced with this stalemate for

a quarter of a century, Dr. Baldwin in 1878 consulted Captain Eads of New Orleans, who had built the jetties at the mouth of the Mississippi River which cleared the New Orleans channel, after much bickering with the Army Engineers. Baldwin did not think jetties were the best answer to the St. Johns Bar problem, but he was desperate for improvement of Jacksonville's port. The Captain studied the St. Johns Bar and made recommendations for the system of jetties that now exists. The Engineers agreed with the plan. Dr. Baldwin returned to Washington in 1880 and succeeded in getting a Congressional appropriation of \$125,000 to begin the work, which was continued steadily over a period of many years until completed. It is interesting to contemplate whether the simple proposal, closure of the Fort George Inlet, would have succeeded in permitting the St. Johns River to maintain its own channel and whether closure of the Inlet coupled with construction of the jetties would have prevented the severe erosion of the beaches as was indirectly suggested by Dr. Baldwin.

Railroad President • In 1852 while on his St. Johns Bar mission to Washington, Dr. Baldwin was elected to represent Duval County in the state legislature.^{2,4} From Tallahassee on January 21, 1853, he wrote a letter to the Editor of the Florida Journal, championing the Florida Atlantic and Gulf Central Railroad. In so doing, he took issue with Governor Call, who had appealed to the citizens of middle Florida to unite in promoting the construction of a railroad to connect the St. Marks and Brunswick roads. Dr. Baldwin was convinced that this route would shunt the trade of the state into Georgia. During his first term in the legislature he succeeded in securing a charter for the Florida Atlantic and Gulf Central Railroad for a road right-of-way from Jacksonville to Pensacola. He organized a company to finance the construction of a railroad through the selling of bonds. He was elected president of the directors of the company in November 1853. In 1857 ground was broken for the road from Jacksonville to Alligator (Lake City), but the yellow fever epidemic in Jacksonville interfered with the work, and there was further delay. The railroad finally reached its destination on March 13, 1860.* In the meantime the town had changed its name to Lake City. Once the construction was completed, Dr. Baldwin resigned as president of the railroad.

Duval County Medical Society Founded • In response to a call issued by Dr. Baldwin, six Duval County physicians met in the office of Dr. William J. L'Engle, on May 25, 1853, and organized the Duval County Medical Society,^{1,2} the first and only county medical society in Florida for two decades. This organization was born in the Republican Building on Bay Street on the southwest corner of Market,

which is now the site of the Jacksonville City Hall, where there is a plaque commemorating the founding of organized medicine in Florida. Merritt stated that Dr. John S. Murdock was elected the first president of the Duval County Medical Society. All available information indicates that Dr. Baldwin was the leader of the group and was responsible for the founding and organization of the society. It is somewhat confusing that Dr. Baldwin's obituary, written by a committee of the Florida Medical Association of which Dr. R.P. Daniel,¹⁸ the first treasurer of the Duval County Medical Society and half-brother of Dr. Murdock was chairman, stated that Dr. Baldwin was not only first president of the Florida Medical Association, but was also first president of the Duval County Medical Society. I was unable to verify this statement.

Abel Baldwin was president of the Duval County Medical Society in 1865 when the eight physicians who were practicing in Jacksonville found times hard and collections difficult. They repeatedly published in the newspaper a resolution to the effect that they were "willing to do the work of charity and administer to the truly indigent but they were not willing to treat persons who were able yet too lazy and dishonorable to make an effort to pay their physicians." Apparently they reported delinquents at society meetings and applied group pressure to see that those who could pay did pay.

In 1860, the town of Thigpen in Duval County was dissatisfied because of the many jokes associated with its name. Pleased with the building of a railroad through their locality, the citizens of the community changed the name of the town to Baldwin, which it carries today.¹⁹

Dr. Baldwin was elected to a second term in the legislature, during which session he fathered a bill creating a temporary internal improvement board, of which he became the member from his district.³ The object of this board was to assist in the building of railroads in the state of Florida. This they did by donating alternate sections of land along the proposed route of the road and endorsing the company's bonds for ironing. This board was afterward made permanent and consisted of the Governor and his Cabinet.

The war years • From the lower House, Dr. Baldwin was promoted by his fellow citizens to the State Senate in 1858.³ Again the election took place while he was out of the city. He was a member of that body when the war broke out. He strenuously opposed secession. Although he was a native of New York and had many friends and relatives in the North, [a cousin, Governor Seymour,¹⁰ was the democratic nominee for President of the United States in 1868], his loyalty was to his adopted land and he was one of the first to volunteer his services at the secession of the State of Florida, January 10, 1861. He was appointed chief surgeon for East Florida.^{2,4} As early

* Presently part of the Seaboard Airline Railway.

as September 15, 1862, a large group publicly thanked him for his efforts at the General Hospital in Lake City. In February 1865, he became medical director of the General Hospitals of Florida and Quitman, Georgia. His Army letter case and account books are preserved in the Confederate Museum at Richmond, Virginia.²

He returned to Jacksonville when the war was over and found that his property had been confiscated.^{2,3} After a few years and an extensive fire he recovered his land possessions. Shortly thereafter he erected an extensive group of buildings on West Bay Street known as the Palmetto Block, which housed 14 stores and many offices. In 1866, Dr. Baldwin was married again, this time to Mrs. Mary E. Dell.³ They had one daughter, Edna Seymour, who married Samuel P. Holmes and whose descendants live in Jacksonville today.**

Florida Medical Association organized • In November 1873, Dr. Baldwin issued a call to doctors in Florida for a meeting to be held in Jacksonville on January 14, 1874.^{2,3 20} Ten physicians from six counties met in the office of Dr. Baldwin at Laura and Adams streets. On his motion, an organization was effected entitled the Medical Association of the State of Florida. The constitution and by-laws of Georgia were adopted until suitable substitutions could be provided at the next annual meeting. Dr. Baldwin was elected unanimously the first President.²¹ He was one of the four members who prepared the constitution and by-laws for the next meeting.

At the second meeting of the Medical Association of Florida, on February 17-18, 1875, Dr. Baldwin made his enlightening address on "The Climatology of Florida," which has been referred to previously.^{6 7} He was re-elected President of the Association, one of three physicians to have held the honor for two terms. At the third meeting of our Association he was appointed a delegate to the American Medical Association convention in Philadelphia.²² Dr. T.M. Palmer was elected President and alternate delegate to the AMA. Because of Dr. Baldwin's outstanding leadership our Association began on a firm foundation and has functioned without interruption since that time.

Although Dr. John P. Wall of Tampa was the first to champion actively a Board of Health and Dr. R.P. Daniel of Jacksonville took up the fight and became the first chairman of the Board of Health, Dr. Baldwin was one of the leaders in persuading the state legislature to establish this Board. In his forthright way, he pointed out that the only reason the Board had not been established was the legislature's refusal to appropriate the \$2,500 necessary for its implementation. The yellow fever epidemic in Jacksonville in 1888 aroused the public interest to the point that Governor Fleming called a special session of the legislature which established the State Board of Health.

Dr. Baldwin was not always successful in his efforts, as indicated by his difficulty in raising money from doctors. Dr. E.P. Wellford, President of the Florida Medical Association in 1878, died while in office.² The society resolved to erect a suitable memorial and a scholarship to medical schools in his honor. Dr. Baldwin was chosen chairman of a special committee to raise funds and choose the memorial. He reported in 1879 that because of inability to raise the funds, the memorial was dropped, which was the only record of surrender found in material relating to this energetic physician.

Community activities • At a time when few men of his age were alive, Dr. Baldwin apparently retired from the practice of medicine, but continued his varied activities for the betterment of his community and his state. A Board of Trade was founded in Jacksonville in 1866.⁴ Dr. Baldwin was a member of the Board. It was during action on this Board that he vigorously promoted improvement of the St. Johns Bar. Apparently, the Board of Trade was reorganized in February 1884, and again Dr. Baldwin was an active participant. In fact, in 1895, at the age of 85 years, he became the seventh president of the Jacksonville Board of Trade.*** His activities on the Board of Trade brought about adoption of a standard time, lowering of telegraph rates and lowering of railroad rates, as well as deepening of and increased shipping on the St. Johns River.

In December 1877, Dr. Baldwin reported on the drainage and sewage in Jacksonville, directing attention to the "pond," a swamp in the middle of present Jacksonville, which was in the same condition as when the yellow fever epidemic began in 1857.² He recommended draining the pond and he criticized several other areas as being unsanitary and in need of drastic action. Much public debate was offered on the issue and on January 15, 1878, a bond issue for \$250,000 was passed in the community by a vote of 625 to 159, which would finance necessary improvements. This was the second bond issue voted by the city, the first having been for \$50,000 in 1857 to help build the railroad. Dr. Baldwin was made chairman of the Sanitary Board Bond Trustees. Without waiting for bonds to be issued, work began on the draining of the pond and was completed by April 1878. A large reservoir was constructed north of Adams Street at Clay and Cedar, for flushing the sewer. It became known as Dr. Baldwin's fish pond. It was surrounded by trees and shrubbery and Dr. Baldwin enjoyed many pleasant hours lounging there during his later years.

** A great grandson, Rogers Baldwin Holmes, is the son-in-law of Dr. Kenneth A. Morris of Jacksonville.

*** The name of the Board of Trade was changed to Chamber of Commerce on January 6, 1915.

In addition Dr. Baldwin succeeded in draining and filling certain lowlands in the city of Jacksonville, improving Hogan's and McCoy's creeks, erecting the Water Works at a cost of \$130,000 and constructing an effective sewage system, as well as a cremator for the consumption of garbage. The last bonds were repaid in 1894, at which time it was said, "The Trustees of the Sanitary Improvement Fund have acquitted themselves of a great responsibility, in a manner most creditable to themselves and beneficial to the community. So perfectly does the system (sewage) work that it is next to impossible for disease to gain a foothold, having no impurities to feed upon." Perhaps this statement is overly optimistic, but we can see that the community was well satisfied with the job performed by our doctor, with his never ending gratuitous services.

He was likewise interested in the beauty of his home community. The magnificent oak trees that made Jacksonville famous in his declining years were a tribute to his foresight when in 1850, nearly half a century before, he joined General Thomas Ledwith to supervise their planting.^{4,23} Unfortunately, they survived him but a short time, for nearly all of them were destroyed by the disastrous fire of 1901.

Life in Florida was apparently difficult for many years following the Civil War, with accusations and counteraccusations regarding civil rights, anarchy, and similar activities. As chairman of the Florida Fruit Growers Association in April 1877, Dr. Baldwin succeeded in gaining the unanimous adoption of a resolution regretting to learn of statements derogatory to Florida in newspapers in the North and West, "representing that Florida people are in a state of anarchy rendering it unsafe for strangers to either visit or become permanent residents of the state." His resolution emphatically denied these statements and declared that Floridians were as quiet and as law-abiding people as any to be found in the Union.²⁴

Dr. Baldwin was a member of the American Scientific Association of Montreal, was a corresponding member of the Boston Natural History Society, and was a frequent correspondent of Agassiz on scientific subjects and natural history for six decades.⁶

For six decades almost to a day, Dr. Baldwin led the vanguard of the public in Jacksonville, Florida. At the time of his death on December 8, 1898, in his eighty-eighth year, he was the city's most distinguished citizen. The report¹⁸ of the Committee on Necrology of the Florida Medical Association in 1899 stated:

Identifying himself thoroughly with the city and state of his adoption, he was ever ready to assist actively in whatever promised to promote the welfare of his fellow citizens; original, progressive, and unselfish, he was not only a distinguished member of our profession, but a most estimable and valuable citizen. The medical profession in Florida owes much to Dr. Baldwin as a pioneer in its path of usefulness and influence...

Such a life record as that made by our departed fellow member and fellow citizen is as admirable as it is rare, and the contemplation of which should stimulate us to emulate the virtues of usefulness which might make our members honored and revered by our fellowmen when the Master calls us hence.

A noble heritage • My tale is told. You have heard the story of this remarkable leader of men. If we think our problems are tough today, if we feel discouraged when we fail to win a few rounds with advocates of political medicine, if we, for even a moment, question the reasons for trying to uphold the principles for which we have been fighting, then let us put ourselves in Dr. Baldwin's shoes — better still, put him in our shoes — and try to think what he might do. His demonstration of fighting for what he thought was right regardless of the odds tells us we cannot let down. His eagerness to better the lot of his community, his state and his fellow man should make us vigilant and progressive, not only in health fields but in related scientific activities and other pursuits that may benefit our state and our country.

As are most physicians, Dr. Baldwin was an individualist, but he was an individualist who saw the need for group action. Only six years after the founding of the American Medical Association, he organized his county medical society; and he did not stop there. Nineteen years later he fulfilled a wider need when he organized the Florida Medical Association.

We, as leaders of Florida medicine, must use the group voice with a cooperative attitude in the things that are best for our patients. We hold the solutions to health problems in our hands, and if we will stick together as a profession we can solve them. Let us be honest in our evaluation of all new programs and their effects on our patients. We must continue to see that people get the medical care they need at a price they can afford to pay. Let us carefully consider every angle. Someone pays, even when government takes over. If we negotiate with the government for the care of the aged who are covered under recently approved programs, we will do well to direct our committees to remember experiences that have been accumulating without a fee schedule, having the doctor charge his reasonable and customary fee.

Since long before the time of Dr. Baldwin, doctors have been noted for giving their services in the care of the needy sick. As recently as February 1965 we indicated overwhelmingly that we wished to continue to do so under the Kerr-Mills program in Florida as it existed at that time. Events have changed our situation, however. We now are faced with a program which assures medical services to some people at a price which is likely to be fixed by government. Actually we are the only ones who can bargain for our services, and although our humanitarian attitude may

have been most exemplary through the years, we have been brought face to face with the hard facts of life, those of selfish politics.

A great many fields of endeavor owe their existence to government payments, government contracts, et cetera. Each year we learn of fortunes which are made by deals with government; yet we, in medicine, have remained starry-eyed, giving government a service and giving indigent patients medical care which will be very costly for government to buy. We must not only do our part in caring for the people but also see that government does its share, paying a fair price for patient care with patients' needs as the foremost consideration, rather than bureaucracy building with its inevitable dictatorship. Let us not relax — let us fight with renewed effort.

I am thankful for Abel Baldwin who brought organization to medicine in Florida, and I thank you active members of Florida medicine for the opportunity to serve this organization through these 15 years. It has been a rewarding experience in many ways. Belatedly, I would like to express my appreciation to Harold Parham, our superb Executive Director, and to the staff at the Florida Medical Association headquarters, without whom I could have accomplished little. I could name many doctors who have been my right arm, but time does not permit. You who are active know who they are. They are the backbone of our group. They are you, and you and you. There have been many headaches and heartaches, and also joy and happiness. My best wishes go to Dr. Hampton, my successor. I pledge him my and your loyal support, and we wish him well.

In one last look at the history of our organization I found that we have had night and day in our leadership. Dr. A.W. Knight was Secretary-Treasurer of the Florida Medical Association for seven years until his death in 1889. Sixty years later a Day followed the Knight and now the Day draws to a close. This Day is done until maybe someday one or more of my sons may bring Daytime again. Thank you.

Editor's Note: President's Address, Read before the Florida Medical Association, Ninety-first Annual Meeting, Bal Harbour, April 22, 1965.

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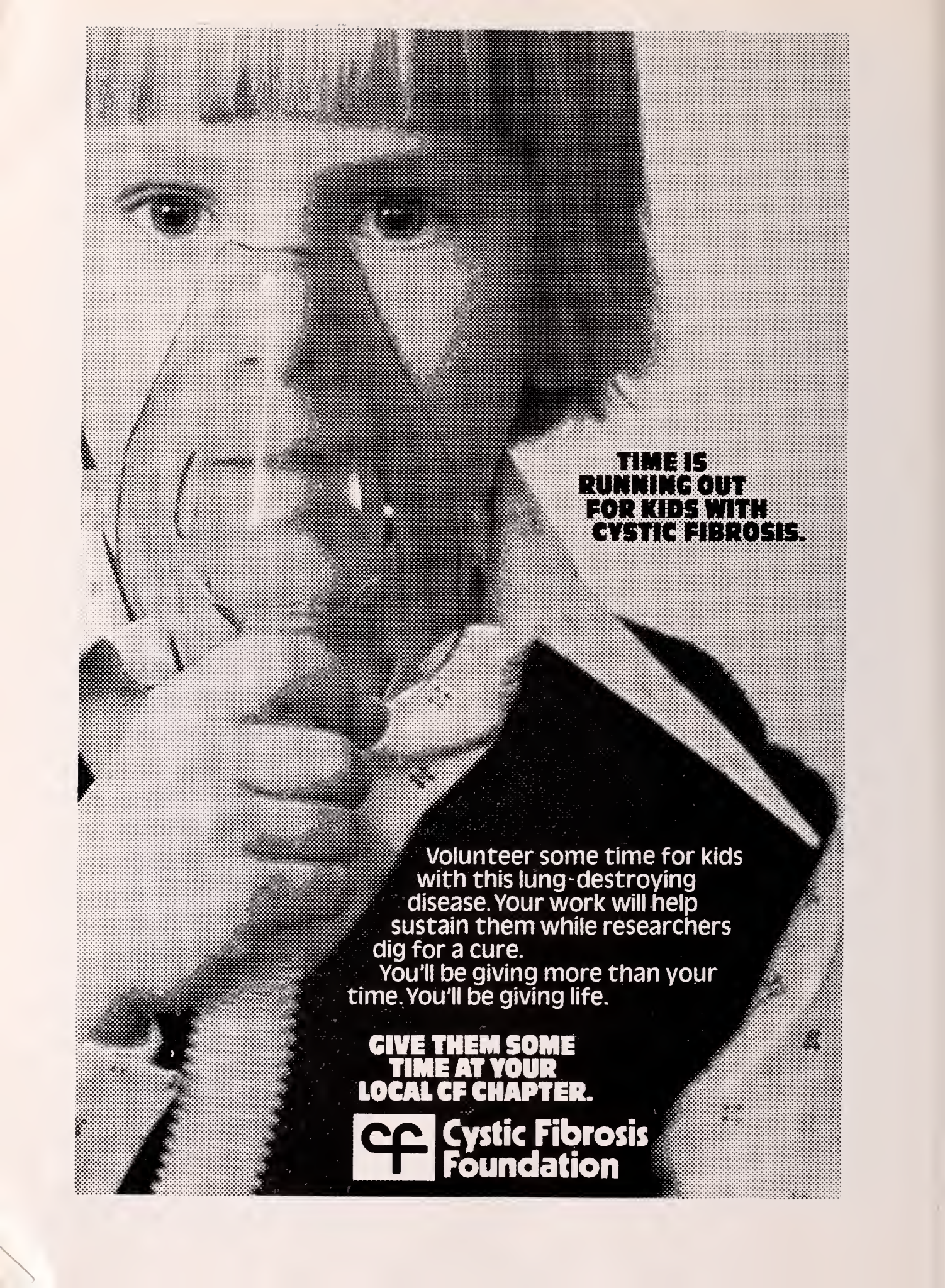
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Samuel M. Day, M.D.
Jacksonville

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View from the AMA Auxiliary Annual Convention

Pomp and circumstance, enthusiasm and sharing were all evident as the AMAA gathered to celebrate its 60th anniversary. It was a time to reflect on our many accomplishments and to see the challenges that lay ahead for us. We are a unique organization united by a common goal of giving our time and ability to help others. As arms of the AMA and FMA, we are proud of our volunteer accomplishments. We have stood the test of time, pioneered major health efforts, and are ready to begin another decade of auxiliary involvement.

With a great deal of pride, our national president, Isobel Dvorsky, presented a check of \$1,742,913.60 to Dr. George H. Mills, AMA-ERF President. In these hard economic times, our Auxiliary has again increased its donations with dedication and much work. In his address to the AMAA House of Delegates, Dr. Mills commended our tireless efforts and generous gifts which are essential to medical schools. Since 1950 when AMA-ERF was begun, we have given 36 million dollars. Dr. Mills also thanked us for our efforts in bringing physicians and spouses together for a common purpose. He saluted us for our determination and success.

John E. Chapman, M.D., Dean of the Vanderbilt School of Medicine and Chairman of the AMA section on medical schools, spoke before our convention with the prime purpose of thanking the Auxiliary. He emphasized that we help shape public opinion which in turn helps shape what the AMA can do. Our flexible resources and unrestricted fund are held in highest regard because these monies are there when the opportunity needs to be taken.

The Auxiliary eagerly listened to Daniel T. Cloud, M.D., President of the AMA, as he read a commendation adopted by the AMA to recognize our 60 years of service to the Association and to the American people. He reiterated the issues that confront medicine today and described an action plan. As Dr. Cloud said, we are truly proud of the AMA as a cornerstone of freedom in our country and are proud of its strength and dedication to goals and principles.

Dynamic, dedicated, intelligent and hard-working are words that describe many spouses that met to

discuss issues, take action, attend workshops, and gather facts and information to keep our volunteer spirit alive. We honored past presidents who served so well, saluted and thanked Isobel Dvorsky our outgoing president, and welcomed our new national president, Betty Payne, who will lead us this coming year as we go on to do bigger and better things. Mrs. Payne is proud of this organization because, "All we have done for medicine is done because we care." Her inaugural address was inspiring and patriotic.

Meeting and greeting, hostessing and campaigning were the goals of our Florida Auxiliary delegation as we helped the FMA at their hospitality room and party for Rufus Broadaway, M.D. We were honored to have an active part and would like to think we helped in our own way to get Dr. Broadaway elected to the Board of Trustees. We were proud to "wear the orange" and represent our great state.

Applause and congratulations, smiles and pats on the backs were all in order as the Florida Auxiliary won two publications awards. The first was for our state newsletter, "The Beeper", selected as the most improved. The second recognition award was won by Orange County for its newsletter, "ACCENTS". Ruth Coleman and Pat Thames proudly accepted these framed certificates. More applause were heard with the announcement that Florida's AMA-ERF fund raising was third in the nation with a total raised of over \$100,000.00 The "orange" delegation cheered for our president, Ruth Coleman, as she gave her "report to the nation" of all our state accomplishments.

The AMAA Convention was exciting and stimulating, informative and challenging. It was a time to reaffirm our commitment to ourselves, our spouses, our communities, our state, and medicine. Our Florida Auxiliary is ready for service and is prepared to meet the challenge of tomorrow. Our founders were innovators who dreamed a dream, and we are the volunteer workers who help make this dream come true.

*Mrs. S. Bruce Gerber
Winter Haven*



These ladies and one gentleman represented the Florida Medical Association Auxiliary at the Annual Meeting of the American Medical Association Auxiliary in Chicago in June. Seated (left to right): Mrs. B. David (Edie) Epestein, Key Biscayne; Mrs. Milton (Jo) Tignor, North Palm Beach; Mrs. S. Bruce (Priscilla) Gerber, Winter Haven; FMA-A President Mrs. Daniel B. (Gloria) Nunn, Jacksonville; Mrs. Frank C. (Ruth) Coleman, Tampa; and Mrs. Linus W. (Jane) Hewit, Tampa. Second row: Mrs. Jerald (Mary) Marks, North Palm Beach; Mrs. Michael J. (Candy) Murray, Fort Myers; Mrs. Richard B. (Connie) Moore, West Palm Beach; Mrs. James (Bebbee) White, Ormond Beach; Mrs. Walter G. (Jody) Jarrell, Jacksonville; Mrs. James (Nancy) Corwin, Atlantic Beach; and Mrs. Joseph (Cheryl) Saiter, Gulf Breeze. Third row: Mrs. Victor (Emily) Dabby, Miami; Mrs. David S. (Sandra) Whittaker, Ocala; Mrs. Thomas B. (Pat) Thames, Orlando; Mrs. Rex (Betty) Orr, St. Petersburg; Mr. Russell Berge, FMA-A Executive Director, Jacksonville; Mrs. Joseph P. (Bea) George, Miami; and Mrs. Humberto (Carmen) Dominguez, Altamonte Springs.

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Meetings

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SEPTEMBER

Technical Aids for the Disabled, Sept. 3-4, Hilton Hotel, Daytona Beach. For information: Convention Management Consultants, 5401 Kirkman Road, Suite 550, Orlando 32805, (305) 351-2592.

Basic Mechanisms and Clinical Applications of Slow-Channel Blockers, Sept. 7, Holy Cross Hospital, Fort Lauderdale. For information: Jon R. Fichtelman, M.D., P.O. Box 23460, Fort Lauderdale 33307.

Hypertensive Emergencies, Sept. 8, Naples Community Hospital, Naples. For information: Steven Preston, M.D., 275 Eighth Street South, Naples 33940, (813) 262-8585.

Common Knee Problems in the Professional Athlete, Sept. 8, Lakeland Yacht and Country Club, Lakeland. For information: Dr. Eugene L. Nagel, M.D., P.O. Box 927, Lakeland 33802.

Tips, Tricks, Traps and Techniques, Recent Developments in Family Practice, Sept. 9-12, St. Augustine. For information: James K. Biggerstaff, M.D., 1406 Kingsley Avenue, Orange Park 32073.

30th Annual Seminar, Florida Affiliate American Diabetes Association, Sept. 10-12, Sheraton Hotel, Bal Harbor. For information: Ronald B. Goldberg, M.D. (305) 547-6657.

Second Annual Symposium on Infectious Disease, Sept. 17-18, Cypress Gardens Quality Inn, Winter Haven. For information: Krish B. Shroff, M.D., P.O. Box 2976, Winter Haven 33880. (813) 299-1277.

Adult Heart Disease, Sept. 17-18, The Medical Center Clinic, Pensacola. For information: Dr. Bruce McCraw, M.D. (904) 478-4121 or (904) 433-4557.

Left Ventricular Dysfunction, Ventricular Ectopy and Sudden Cardiac Death, Sept. 21, Holy Cross Hospital, Fort Lauderdale. For information: Jon Fichtelman, M.D., Post Office Box 23460, Fort Lauderdale 33307.

Annual Topics in Neurology, Sept. 23-25, Marriott Marco Bch. Resort, Marco Island. For information: William D. Ertga, M.D., 201 Eighth Street, Suite 103, Naples 33940. (813) 262-8971.

Basic, Intermediate and Advanced Workshop in Clinical Hypnosis, Sept. 23-26, Holiday Inn Florida Center, Orlando. For information: Charles Mutter, M.D., Educational Research Foundation, (305) 547-2000.

Angiotensin Converting Enzyme Inhibitor Therapy, Sept. 30, Good Samaritan Hospital, West Palm Beach. For information: Daniel N. Tucker, M.D., P.O. Box 3166, West Palm Bch. 33402. (305) 655-5511 or (305) 832-8531.

OCTOBER

16th Family Practice Review, Oct. 4-8, Hotel Royal Plaza, Lake Buena Vista. For information: Lamar Crevasse, M.D., Box J-233, JHMHC, Gainesville 32610.

Management of Burn Victims: Emergency, Acute and Rehabilitative Phases, Oct. 7-8, Miami. For information: Ms. Gloria Allington, (305) 547-6716.

8th Annual OB/GYN Review Course, Oct. 8-16, Royal Biscayne Hotel, Key Biscayne. For information: University of Miami School of Medicine (305) 547-6944.

First Annual Wuesthoff Memorial Lecture Series: Recent Advances in Medicine and Surgery, Oct. 9, Wuesthoff Memorial Hospital, Rockledge. For information: George Leal, M.D., 1395 N. Courtenay Parkway, Merritt Island 32952. (305) 452-2563.

OB/GYN Pathology Review Course, Oct. 10-12, University of Miami School of Medicine, Dept. of OB/GYN, P.O. Box 016960, Miami 33101, (305) 547-6944.

RX for a Healthy Heart, Oct. 10-15, Sheraton Sand Key Hotel, Clearwater. For information: Henry J.L. Marriott, M.D. (813) 894-0790.

Pediatric Nephrology, Oct. 11, International Hospital, Miami. For information: Alfredo Crucet, M.D., and Marcella Schaible, (305) 547-6604.

Violent Crime: An Epidemic, October 13, Quality Inn, Cypress Gardens, Winter Haven. For information: Eugene L. Nagel, M.D., P.O. Box 927, Lakeland.

Principals of Practice Management, Oct. 13-17, Hot Springs, Virginia. For information: Univ. of Miami, Dept. of Anesthesiology, School of Med., P.O. Box 016960, Miami 33101. (305) 547-6411.

Brief and Emergency Psychotherapy: A Seminar, Oct. 14-15, Sarasota Hyatt House, Sarasota. For info.: Nancy Skotchdopole, ACSW, P.O. Box 2024, Leesburg, 32748, (904) 787-9178.

Regional CME Meeting — 14th Annual Joint Meeting American College of Physicians and Florida Society of Internal Medicine, Oct. 15-17, Hyatt Regency, Tampa. For information: Roy H. Behnke, M.D. Univ. of S. Fla. College of Medicine, 12901 N. 30th St., Tampa 33612. (813) 974-2271.

89th Annual Meeting of the Association of Military Surgeons of the U.S., Oct. 17-21, Convention Center, Sheraton Twin Towers Hotel, Orlando. For information: Captain Jay R. Shapiro, USPHS (305) 496-3515.

An Update and Review in Emergency Medicine, Oct. 18-22, Sonesta Beach Hotel, Key Biscayne. For info.: Sharon G. Llera, 8200 West Sunrise Blvd. Bldg. C. Plantation, 33332. (305) 472-6922.

Annual Panamerican Seminar, Oct. 18-22, Mt. Sinai Hospital, Miami. For info.: Dept. of CME, Mt. Sinai Medical Center, 4300 Alton Road, Miami Beach 33140. (305) 674-2311.
(Totally in Spanish)

Annual Medical Aspects of Aging, Oct. 22-23, Gainesville Hilton, Gainesville. For information: Ms. Grace Wagner, Coordinator, University of Florida CME, Box J-233, JHM Health Center, Gainesville 32610, (904) 392-3143 or 3183.

Annual Meeting, American Pain Society, Oct. 29-31, Konover Hotel, Miami Beach. For information: Kenneth L. Case, M.D., Neurology Service, VA Medical Center, Ann Arbor, Michigan 48105. (313) 769-7100 Ext. 296.

23rd Annual Workshop in Electrocardiology, Oct. 28-Nov. 1, Sheraton Sand Key Hotel, Clearwater Beach. For information: Henry J.L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705, (813) 894-0790.

Annual Meeting, American Pain Society, Oct. 29-31, Konover Hotel, Miami Beach. For information: Kenneth L. Casey, Neurology Service, VA Medical Center, Ann Arbor, Michigan 48105, (313) 769-7100, ext. 296.

Current Advances in Perinatology, Oct. 31-Nov. 6, St. Thomas, U.S. Virgin Islands. For information: University of Miami School of Medicine, Dept. of Pediatrics, P.O. Box 016960, Miami 33101, (305) 547-6411.

NOVEMBER

Pacemaker Electrocardiography and Dual Chamber Pulse Generators, Nov. 3-5, Wolfson Auditorium, Mount Sinai Medical Center of Greater Miami, Miami Beach. For information: Philips Samet, M.D., (305) 674-2311.

Psychopharmacology for the Practicing Internist, Family Practitioner & Psychiatrist, Nov. 4, 5, 6, Dutch Resort Hotel, Orlando. For information: Robert Needleman, M.D. (305) 841-5144.

Clinical Management of Coronary Disease and Dual-Mode Exercise Testing, Nov. 5-7, Hilton Gateway, Orlando. For information: Stephen E. Mattingly, International Medical Education Corporation, 64 Inverness Drive E., Englewood, Colorado 80112.

Glimpses Forward — Clinical Applications of New Diagnostic Imaging and Interventional Techniques, Nov. 11-13, Wolfson Auditorium, Mount Sinai Medical Center, Miami Beach. For info.: Manuel Viamonte Jr., M.D., 4300 Alton Road, Miami Beach 33140, (305) 674-2311.

Advances in External Fixation Nov. 12-14, Univ. of Miami School of Medicine, Miami. For info.: Univ. of Miami School of Medicine, Dept. of Orthopedics (D27), P.O. Box 016960, Miami 33101. (305) 547-6996.

Update Gastrointestinal Diseases, Nov. 13, Caribbean Gulf Hotel, Clearwater. For info.: Walter W. Hamilton, M.D., Palms of Pasadena Hospital, 1501 Pasadena Avenue, St. Petersburg 33707. (813) 345-9301.

Medical Oncology Grand Rounds, Nov. 19-20, UF College of Medicine, Gainesville. For information: Roy S. Weiner, M.D., Chief of Medical Oncology, Box J-277, JHMC, Gainesville 32610. (904) 392-4611.

Maxillofacial Pain Symposium, Nov. 20 and 21, Gainesville Hilton, Gainesville. For information: Marvin M. Slott, M.D., 6510 N.W. 9th Blvd., Suite #4, Gainesville 32605, (904) 377-2016.

DECEMBER

Clinical Allergy and Immunology for the Practicing Physician, Dec. 2-4, Dutch Inn Resort Hotel, Lake Buena Vista. For information: Richard F. Lockey, M.D., University of South Florida, College of Medicine, Division of Allergy, (813) 971-4500, ext. 596.

Neuro-Ophthalmology, Dec. 2-4, Miami. For information: University of Miami School of

Medicine, Dept. of Ophthalmology (D880), P.O. Box 016960, Miami 33101.

ECG Interpretation and Arrhythmia Management, Dec. 3-5, Bahia Mar Hotel, Fort Lauderdale. For information: International Medical Education Corp., Division of Postgraduate Education, 64 Inverness Drive E., Englewood, Colorado 80112.

Advances in Technology for the Management of Musculoskeletal Disability, Dec. 6-8, Miami. For information: Univ. of Miami School of Medicine, Dept. of Orthopedics (D27), P.O. Box 016960, Miami 33101.

Ultrasound As Used In Modern Obstetrics and Gynecology, Dec. 8-12, Miami Beach. For information: University of Miami School of Medicine, Dept. of OB/GYN, P.O. Box 016960, Miami 33101.

Human Sexuality, Dec. 9-11, Disney World, Orlando. For info.: Pat Taylor, c/o Pedro Bachrach, M.D., 701 E. Semoran Blvd. #108, Altamonte Springs, 32701. (305) 323-7772.

Interamerican Medical Symposium — 3rd Annual Course, Dec. 12-17, Miami Beach. For information: Dept. of Medicine (R760), P.O. Box 016960, Miami 33101.

JANUARY 1983

28th Annual Cardiovascular Seminar, Jan. 7-8, Dolphin Beach Resort, St. Petersburg Beach. For information: Mr. E. Jerry Eatman, P.O. Box 7188, St. Petersburg 33734.

6th Annual Review in Oral Pathology, Jan. 10-14, University of Miami, Miami. For information: University of Miami CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

Coexistent Pulmonary and Cardiac Disease, Jan. 12, Mount Sinai Medical Center, Miami. For information: Marvin L. Meitus, M.D. and Adam Wanner, M.D., 4300 Alton Road, Miami Beach 33140, (305) 674-2311.

Grand Prix Road Racing — Medical Aspects, Jan. 12, Peace River Country Club, Bartow. For information: Mrs. Elsie Trask, Exec. Dir., Polk County Medical Society, (813) 682-0543.

8th Annual Review and Recent Practical Advances in Pathology, Jan. 17-21, University of Miami, Miami Beach. For information: Univ. of Miami School of Medicine, Dept. of Pathology, P.O. Box 016960, Miami 33101, (305) 325-6437.

Acute Spinal Cord Injury — Comprehensive Management, Jan. 19-23, Univ. of Miami, Miami. For information: CME, University of Miami School of Medicine, P.O. Box 016960, Miami 33101, (305) 547-6716.

Continuing Education in Pediatrics — 1983, Jan. 23-27, Diplomat Hotel, Hollywood. For information: Donald H. Altman, M.D., 6125 Southwest 31st Street, Miami 33156. (305) 667-7060.

Round Table Day, Jan. 28, Diplomat Resort, Hollywood. For information: Donald H. Altman, 6125 Southwest 31st Street, Miami 33156. (305) 667-7060.

Symposium on Intensive Care, Jan. 29 - Feb. 5, Vail, Colorado. For info.: University of Miami School of Medicine, P.O. Box 016960, Miami 33101. (305) 547-6411.

Pediatric Nephrology Seminar X, Jan. 30-Feb. 3, University of Miami, Miami. For information: University of Miami, Department of Pediatrics, P.O. Box 016960, Miami 33101, (305) 325-6726.

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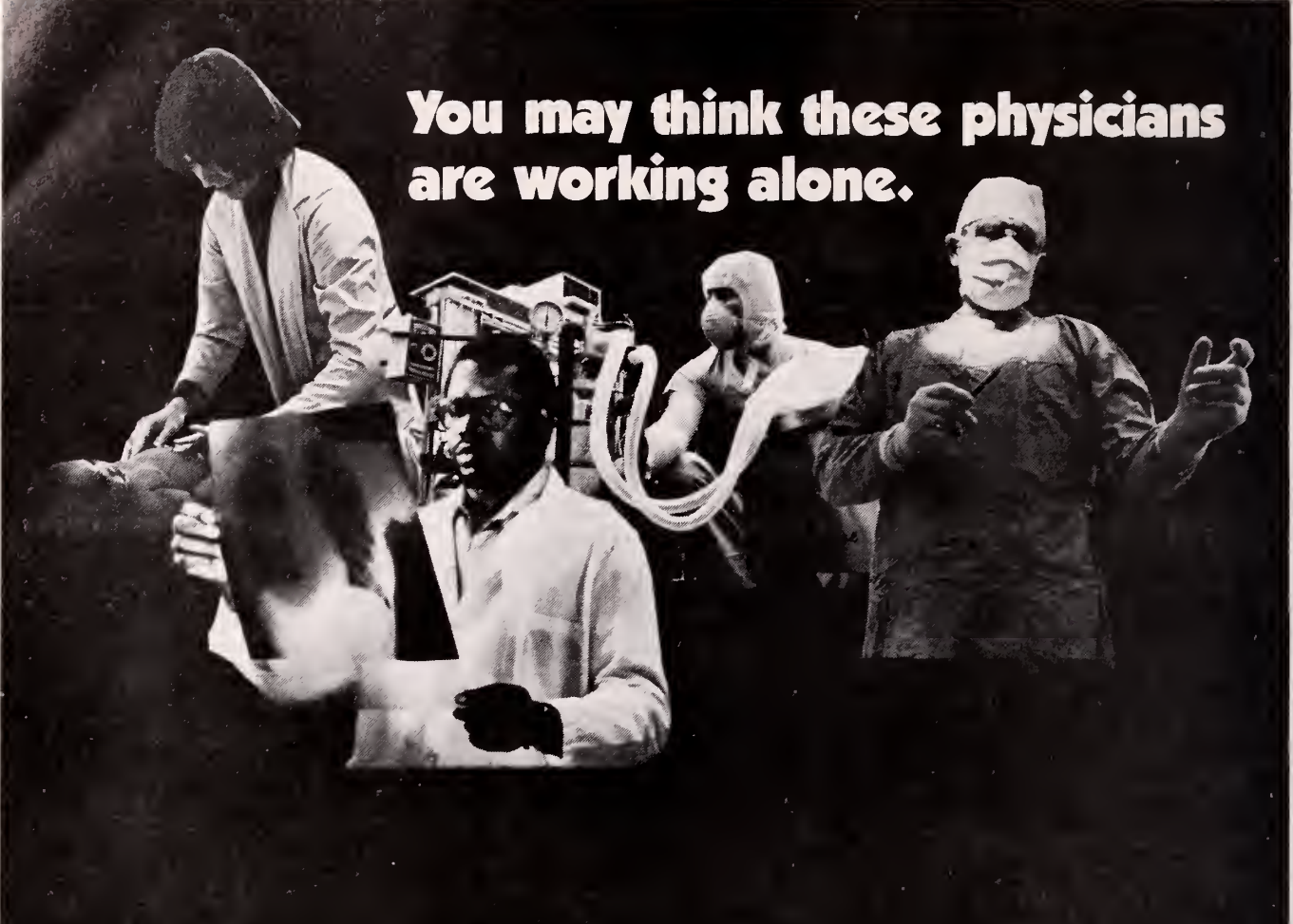
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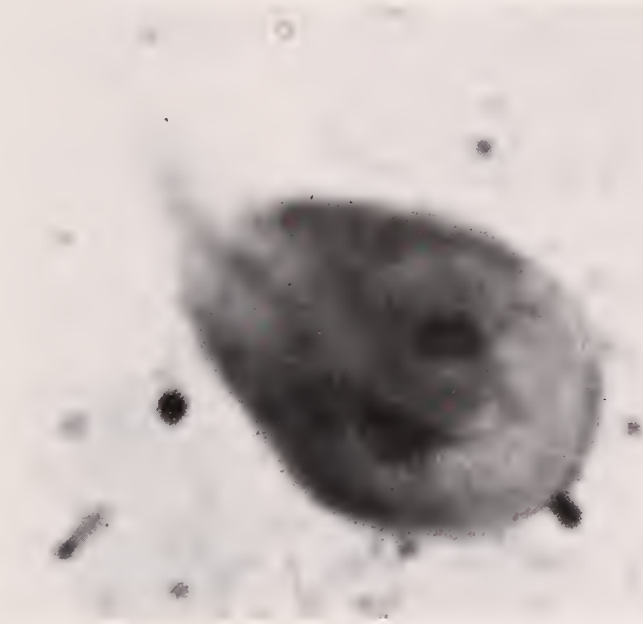
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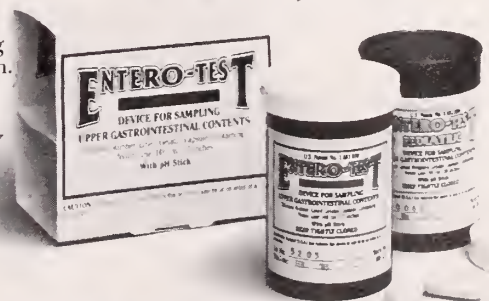
Giardia lamblia

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- AGOS, ISADORE H., Hollywood; born 1898; University of Georgia, 1921; died 1982.
- ALVAREZ, ANSELMO SEGUNDO, Tampa; born 1920; University of Havana, 1948; died 3/27/82.
- ALVAREZ, MIGUEL MIARI, Miami; born 1893; Medical School of Havana University, 1912; died 6/21/1979.
- AMOEDO, JOSE MANUEL, Ft. Lauderdale; born 1912; University of Havana, 1934; member AMA; died 2/10/81.
- ARMSTRONG, ALLAN L., Tampa; born 1923; University of Virginia Medical School, 1949; died 1/21/82.
- AUSTIN, GEORGE CURTIS, Miami; born 1910; University of Virginia, 1934; died 1982.
- BENCOMO, PEDRO MARIANO, Miami; born 1926; Havana University, 1951; died 1982.
- BENTON, CLEM (CORNELIUS), Fort Pierce; born 1898; Meharry Medical College, 1929; member AMA; died 5/3/82.
- BIRD, WILLIAM WYLIE, Jacksonville; born 1948; Medical University of South Carolina, 1976; died 2/3/82.
- BLITCH, CLIFFORD GORDON, Tallahassee; born 1/29/04; Vanderbilt Medical School, 1928; died 1/21/82.
- BONOMO, ROBERT, Ft. Lauderdale; born 1922; University of Rome, 1940; member AMA; died 8/23/81.
- BROWN, CARLETON JUSTUS, Jacksonville; born 2/4/22; Yale University College of Medicine, 1942; member AMA; died 12/7/81.
- BRUNOEHLER, CARL JOHN, Winter Park; born 1925; Indiana University, 1948; member AMA; died 11/5/81.
- BURRY, ROBERT OBERLIN, Ft. Lauderdale; born 1913; Western Reserve, 1942; member AMA; died unknown.
- CALVO, RAFAEL S., Orlando; born 1928; University of Havana, 1969; died 6/16/82.
- CASUSO, GABRIEL EDUARDO, Miami; born 1920; University of Havana, 1948; died 1/6/81.
- CHRISTIAN, WILLIAM ARNOLD, St. Petersburg; born 1910; University of Illinois, 1931; member AMA; died 9/18/81.
- CLARHOLM, VICTOR, West Palm Beach; born 1905; McGill University, 1931; member AMA; died 3/21/79.
- CONGER, GEORGE DREW, Miami; born 1897; Emory University and University of Tennessee, 1925; member AMA; died 1981.
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QUICKSALL, JOHN BRADEN, Marietta, Georgia; born 1904; University of Pennsylvania, 1927; died 1981.

READ, FRANCES ELBA MYRTLE, Ft. Lauderdale; born 1911; McGill University, 1933; member AMA; died 1/14/82.

ROBERTS, CHARLES McWHORTER, Melbourne; born 1924; Tulane University, 1953; member AMA; died 3/7/82.

ROSSI JOHN SALVATORE, San Jose, California; born 1904; Long Island College, 1929; died 1981.

SAPP, EDWIN EUGENE, Jacksonville; born 1927; Medical College of Georgia, 1953; died 12/6/81.

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STANNUS, DONALD GEORGE, Miami; born 1912; Rush, 1937; died 1981.

STEINMAN, ARTHUR, Daytona Beach; born 1942; Hahnemann Medical College, 1968; died 12/22/81.

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WEILAND, ARTHUR HERMAN, Miami; born 1894; Rush Medical College, 1921; member AMA; died 10/26/81.

WHITE, WALTER MOTLEY JR., Miami; born 1916; University of Virginia, 1943; member AMA; died 1/82.

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Our friend and we were invited abroad on a party of pleasure, which is to last forever. His chair was ready first, and he is gone before us. We could not all conveniently start together; and why should you and I be grieved at this, since we are soon to follow, and know where to find him?

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
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MATURE MEDICAL STUDENT, North American, studying in Mexico, going into fourth medical year September 1982. Seeks URGENTLY guidance and funding. Advertiser speaks: Spanish, German, Polish and Italian besides English and is interested in Geriatrics. She and children agree to work one year for each year of support for the sponsor organization. Contact: C-1102, P.O. Box 2411, Jacksonville, FL 32203.

34 YEAR OLD FLORIDA licensed physician. Board eligible in Family Practice. Would like to relocate to Ft. Lauderdale area. All clinical opportunities will be considered. Call David S. Schwartz, M.D., (212) 570-6353 after 6 p.m.

PULMONARY INTERNIST ABIM, FLEX, 30 years old. Completing fellowship July 1982, experienced in all aspects of Pulmonary and Critical Care, willing to do some internal medicine, seeks private practice opportunity. All locations. K.J. Shah, M.D., 44-36, Ketcham St., Elmhurst, N.Y. 11373. (212) 426-2231.

MEDICAL ONCOLOGIST: Board eligible, ABIM, university trained, desires position in Florida available July 1983. Reply to: C-1098, Post Office Box 2411, Jacksonville, Florida 32203.

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WANTED TO BUY: Internal Medicine or Cardiology Practice. Would also consider buying General practice. Reply all details: C-1081, Post Office Box 2411, Jacksonville, Florida 32203.

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DOCTOR, WE KNOW YOUR BUSINESS. With 27 years experience as a Hospital Administrator, Bill Bishop, F.A.C.H.A., understands your needs! He can help you find qualified candidates for that hard to fill position of Office Manager, or Clinic Manager. Bill Bishop and Associates, Inc., Health Care Executive Search Consultants, 1045 Riverside Ave., Jacksonville, Florida 32204, (904) 354-1050.

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BIOFEEDBACK FOR SALE Autogen 1700 with EMG and thermal and audio feedback. Contact Dr. Dorothy Twitchell, P.O. Drawer 460, Coco Beach, Florida 32931.

Heart Healthy Recipe

APPLE MUFFINS

- 6 tablespoons oil
- $\frac{1}{3}$ cup sugar
- 1 egg (or 2 egg whites or egg substitute equivalent to 1 egg)
- $1\frac{1}{2}$ cups skim milk
- 1 cup whole wheat flour
- 1 cup buckwheat flour
- $\frac{3}{4}$ teaspoon salt
- 4 teaspoons baking powder
- $\frac{3}{4}$ teaspoon cinnamon
- $\frac{1}{4}$ teaspoon nutmeg
- 1 large apple, chopped

Stir together oil, sugar, egg and milk.

Mix together the dry ingredients.

Add liquid mixture to dry ingredients, stirring only enough to moisten the flour, then add the chopped apple.

Dip the batter into oiled $2\frac{1}{2}$ -inch muffin tins, filling each cup $\frac{2}{3}$ full.

Bake at 400°F. for 20-25 minutes. Yield: 18 $2\frac{1}{2}$ inch muffins. Approx. cal/serv.: 115

Heart Healthy Recipes are from the Third Edition of the American Heart Association Cookbook. Copyright © 1973, 1975, 1979 by the American Heart Association, Inc.



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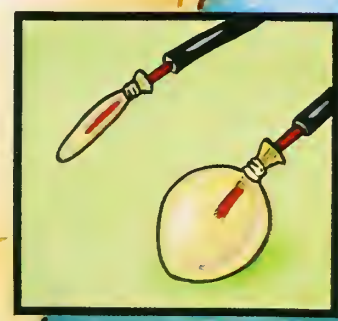
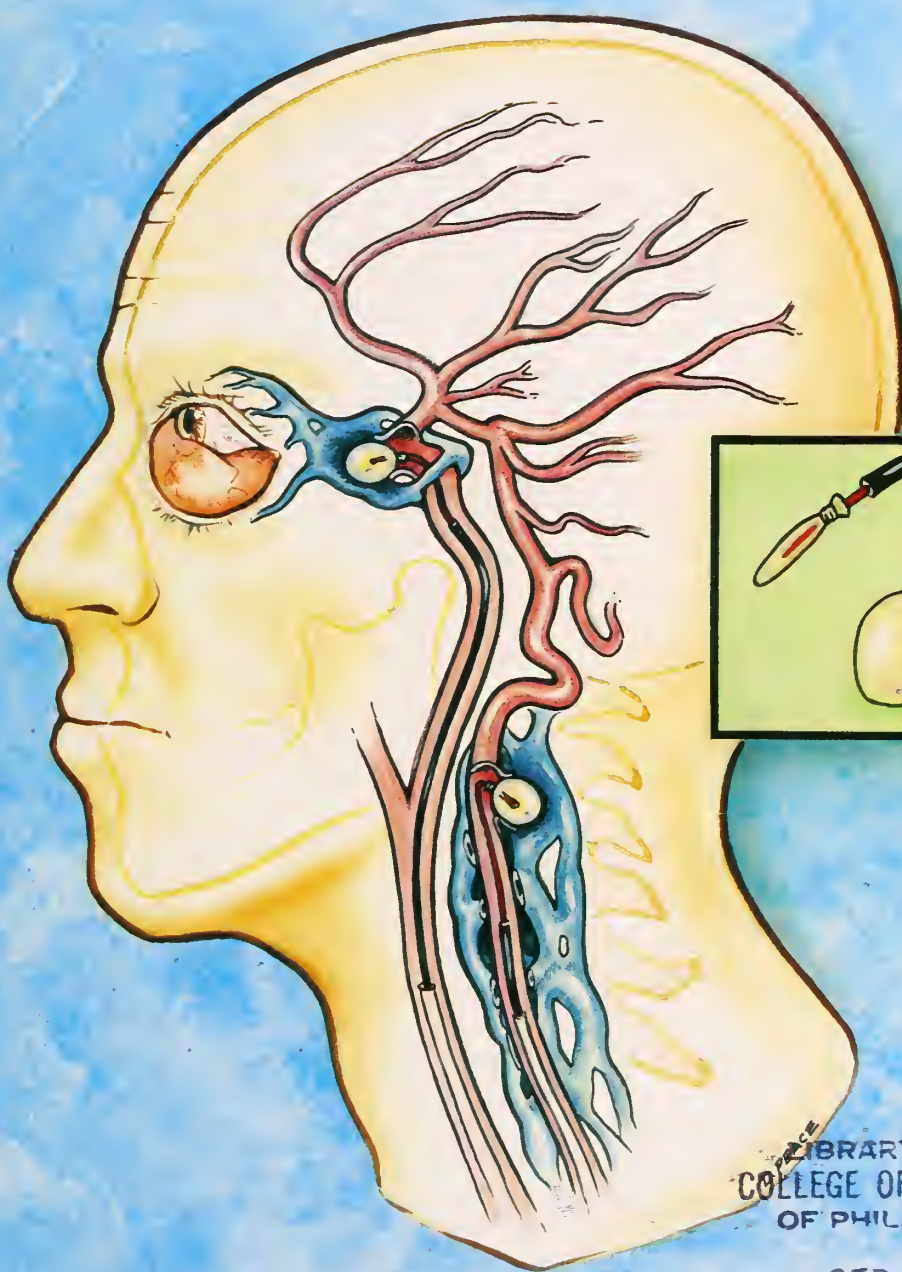


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August 18, 1982

A PROGRAM OF "REASON" - - - DEFENDANTS' RIGHTS IN CIVIL ACTIONS

Dear Colleague:

In continuation of the FMA's dynamic program to resolve the professional liability crisis in Florida on a long-term basis, the Association has adopted a three-fold program for defendants' rights in civil actions which will include the following:

Legislative Recommendations to the 1983 Legislature

- A) Mandatory statutory periodic payment of all future economic damages such as hospital and medical bills, loss of earnings or earning capacity, and attorneys' fees, with the reverter of unexpended funds for medical expenses to the party paying these expenses should the claimant die or some other event occur where funding is no longer necessary, prior to the termination of the period of years during which such payments are to be made, and that this provision be applicable to all personal injury cases.
- B) Transfer of punitive damage allegations from civil litigation cases to the criminal court system with damages payable to the state of Florida.
- C) Removal of joint and several liability in personal injury cases.
- D) Limitation of attorneys' fees (pursuant to the New Jersey Supreme Court Schedule) based upon the amount of recovery in civil litigation.
- E) Establishment of a mandatory statutory limitation (\$250,000.00) on recovery of damages for pain and suffering and other non-economic losses: mental anguish, loss of capacity for enjoyment of life, etc., that would be applicable to all personal injury cases.
- F) Establishment of a statutory provision regarding the application of the summary judgment procedure in all civil cases.
- G) Strengthening of existing statutes relative to remittitur-additur requiring the trial judges to reduce or increase a jury award when it is excessive or inadequate.

Judicial Petitions to the Florida Bar and Florida State Supreme Court

- A) Adopt the New Jersey concept for contingency fees limitations.
- B) Adopt a stronger rule regarding the application of summary judgments.
- C) Adopt a pre-trial screening panel mechanism for the resolution of civil actions.


Constitutional Revision

- A) Creation of a new right in Article I of the Florida Constitution entitled "Rights of Defendants in Civil Actions" that would provide for summary judgments, limitation on general and non-economic damages and for the elimination of joint and several liability.
- B) Removal of the requirement that a Justice of the Supreme Court be a member of the Florida Bar (an attorney), thus opening membership on the Supreme Court to non-lawyers. (Same qualifications as Governor.)
- C) Removal of attorneys' licensure and discipline from the jurisdiction of the Florida Supreme Court and regulation by general law in the same manner as other professions, e.g., Department of Professional Regulation.
- D) Repeal of provisions of the Constitution relating to the Judicial Nominating Commission for Supreme Court Justices, thus requiring Supreme Court Justices to be elected by the electors of the state, as other state and county officials are elected. (Whether partisan or non-partisan to be determined.)
- E) Adoption of a requirement that the Supreme Court of Florida by rule establish a procedure for the processing of civil actions with the view toward discouraging baseless actions and encouraging settlement of those actions based on reasonable probability, e.g., the creation of a court rule of pre-trial screening panels.

This program is a result of in-depth deliberations and tremendous work over a period of years, and will receive the Association's highest priority in working toward its successful achievement.

You will be receiving additional information regarding the program and, as I have pointed out to you in my previous letters, your total personal commitment to assisting with this effort is essential to its success. Your cooperation when called upon to help will benefit you, your colleagues, and your patients.

Sincerely,



Robert E. Windom, M.D.
President

A PROGRAM FOR DEFENDANTS' RIGHTS

REASON

Rationale et Justitia
(With Reason and Justice)



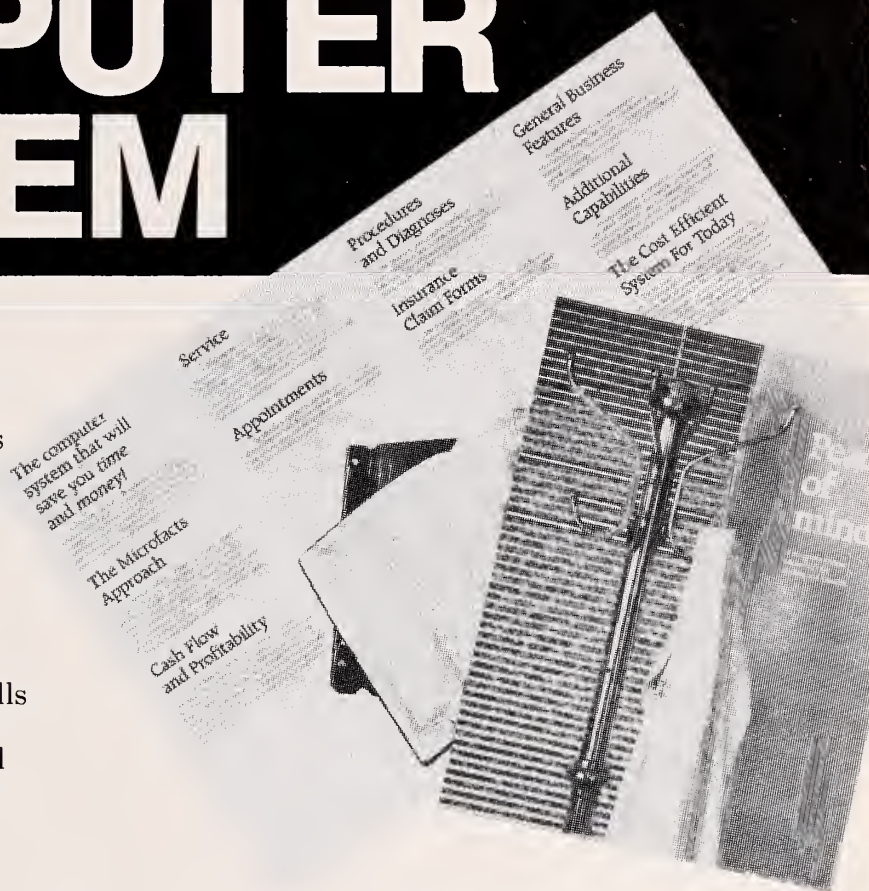
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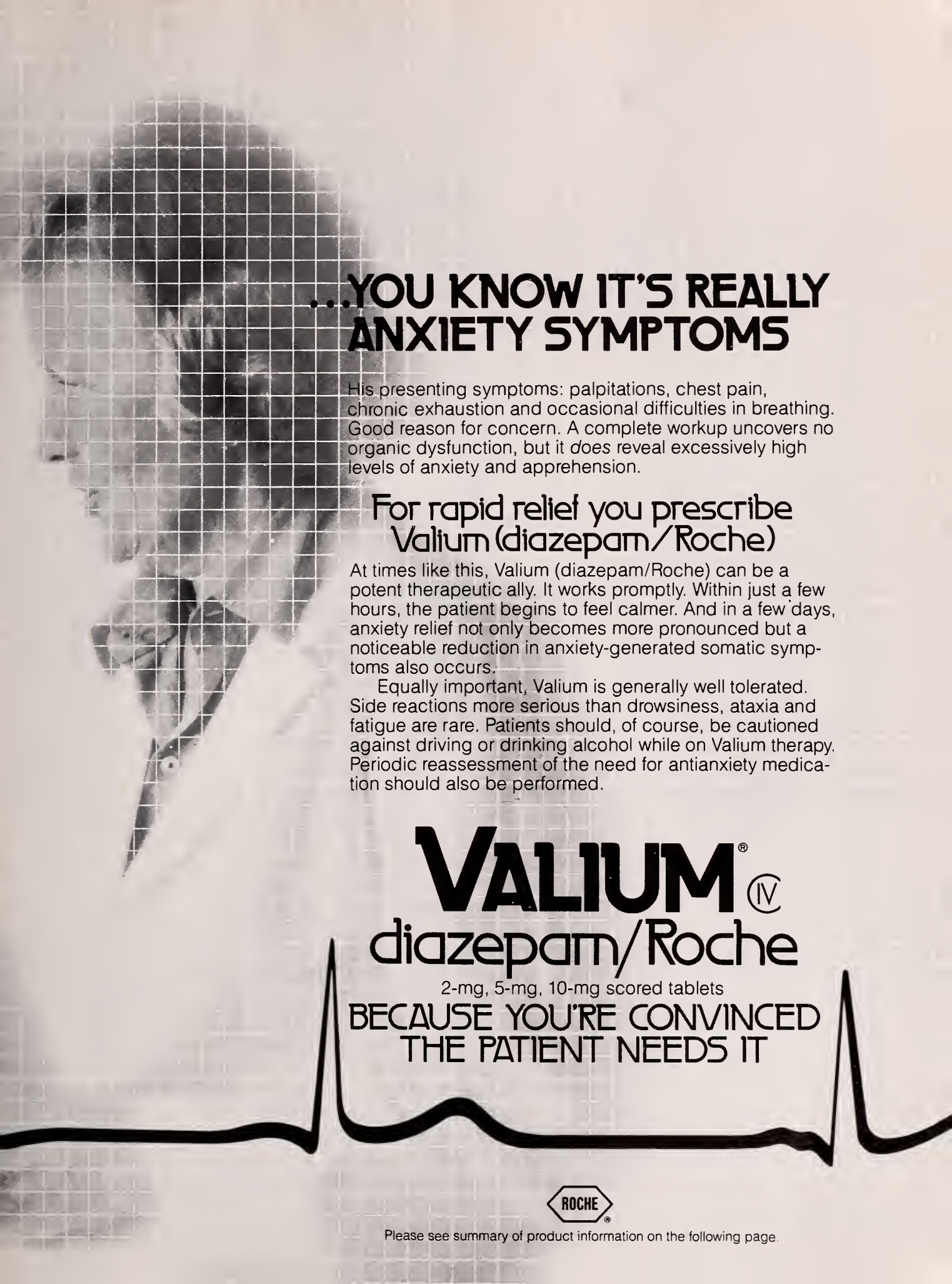


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The effectiveness of Valium (diazepam, Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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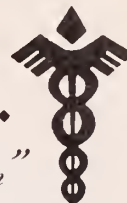
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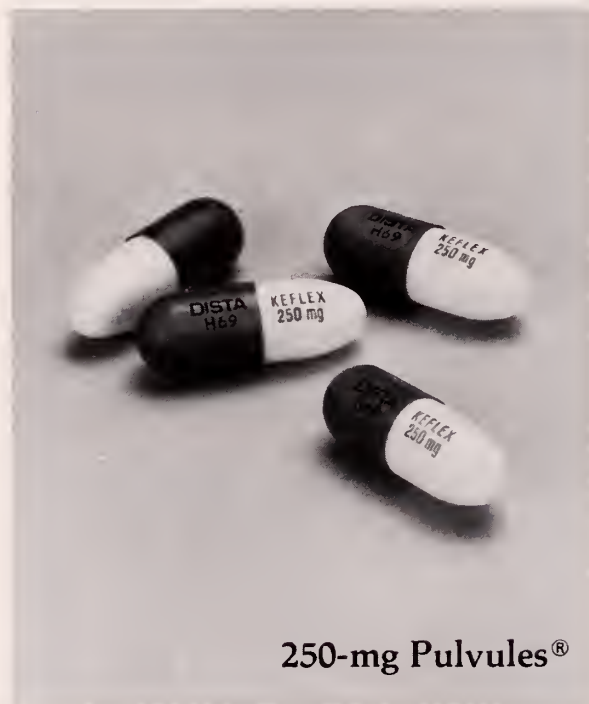
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EDITORIAL

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COVER

The schematic demonstrates the placement of an inflatable latex balloon transarterially through a carotid-cavernous and a vertebro-vertebral fistula. This new technology is safer, less expensive and at least as effective as previously utilized surgical procedures. See "Balloon Embolization of High-Flow Traumatic Arteriovenous Fistulae to the Brain" by Drs. Mickle and Quisling on page 767 for additional information. Artwork by David Peace, medical illustrator for the Department of Neurosurgery at Shands Hospital in Gainesville.

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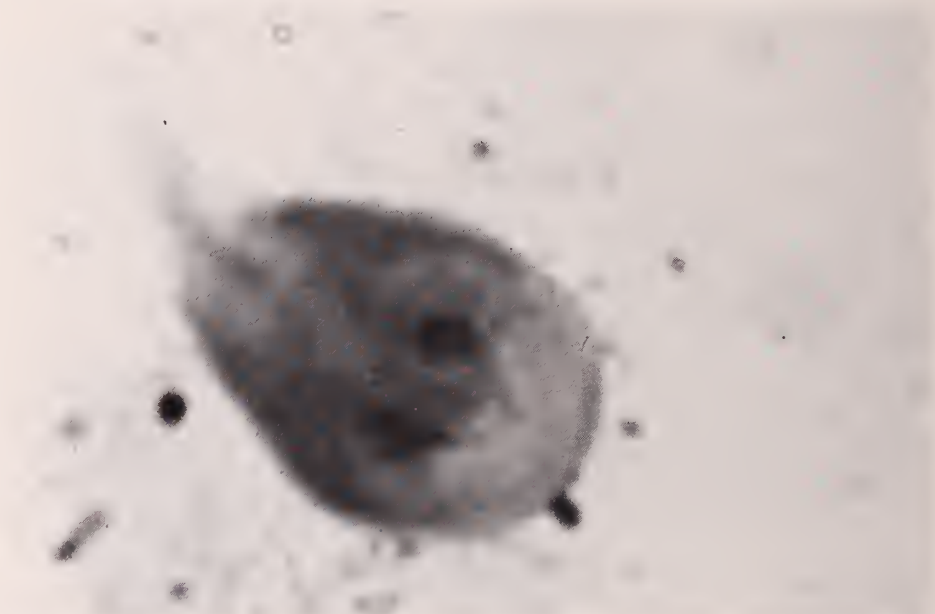
Those parasites that live primarily in the duodenum or bile ducts often are more readily seen in the duodenal contents than in the stool. These include *Giardia lamblia* (motile trophozoites), *Strongyloides stercoralis* (larvae and/or eggs in advanced stages of development), *Clonorchis sinensis* (eggs), *Fasciola hepatica* (eggs), *Trichostrongylus orientalis* (eggs), and *Isospora* (coccidia).

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INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS **PREGNANCY:** VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets. VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

US Patent 3,657,267
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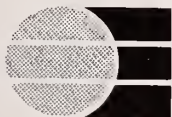
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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.¹

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.²

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.³

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, light-headedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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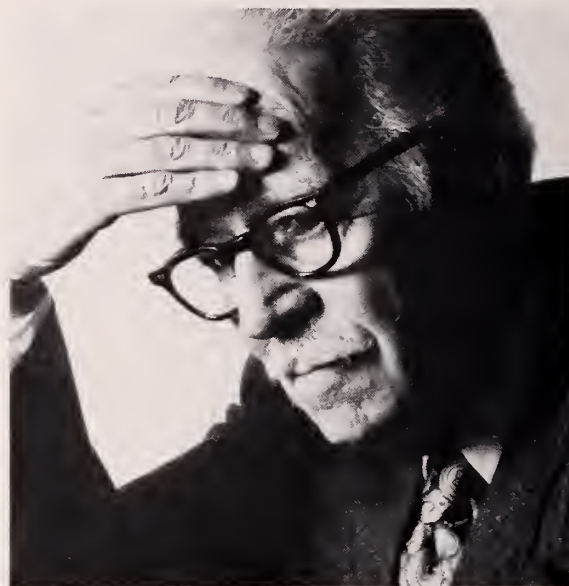
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"Possibly" effective: For the relief of angina pectoris (pain of coronary artery disease). ISO-BID is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris. Final classification of the less-than-effective indication requires further investigation.

CONTRAINDICATION: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Use with caution in patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness

and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.

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1. Shane, S.J.: Canadian Family Physician. November 1973.
2. Lemberg, L.: Practical Cardiology. February 1976.
3. Abrams, J.: New England Journal of Medicine. May 29, 1980.

The Game Plan

Fall is upon us. Football is in the air. Children are back in school. Vacations are history for 1982 for many families.

The 1982 election primaries will soon be behind us and the first team for each party will be selected and ready for the big game November 2. Enthusiasm is high in each camp as strategies are finalized for the big push.

How does this scenario affect the FMA? Our package for broad-based professional liability reform is complete after long hours of work by many knowledgeable people. Our strategy is programmed. What is our next step?

To be victorious for a medical team is no different from winning in football. You need a *team* of players whom you know will follow your game plan and play their hearts out to win. How do we get those kinds of players? Simple! The draft choices will be before us on November 2. Our job is to start *NOW* by urging each of our colleagues in Florida to get involved in the political process by giving of their time, money, and effort to help select our championship team. Of course, we cannot expect that we will be 100 percent effective, but it is a sure bet we will be 100 percent *ineffective* if each of us does nothing. That is why I am using this opportunity to make you — the physician — aware of how vital it is for you to do *something* — you! you! you! Let's not pass the buck to someone else — that's conceding defeat right away.

Each of you has received the FMA's extensive professional liability program that will be pursued through the Legislature, the Judiciary and the public during 1982-83. It should not be set aside to be read when time permits, or to be forgotten. It contains important and detailed information that requires repeated reference to make it "come naturally" to you so that you can explain it to your selected candidates and to your friends who will vote for them,



and ultimately to your legislators who will address this issue next spring. Your office staff can be helpful — just let them know the consequences if we don't win — there is no second half in this season.

Our greatest support team is our FMA Auxiliary. This group of loyal spouses has a remarkable track record in previous legislative efforts on our behalf. They do much of the leg work — thus the name "Legs Alert" — which their physician spouses often cannot do. They speak and act on our behalf because they understand the problem and how important it is not only for medicine, but to our patients and for society as a whole.

Less than two months remain for us — each one of us — to select our draft choice. In your community you know the candidates for our State Legislature better than anyone else. Make your contact with each one — in person, or by phone call. Express your concerns, briefly explain the problem, and ask what else you can do. Follow up a week or so later to see if there are any questions; be sure he or she understands the issue and if they are willing to help. By then you will know whom you can support and for whom you will work hard to elect in November.

We have our game plan underway. It will work, but only if we all commit the combined strength and energy of our entire team in working toward a common goal. We can't afford any deviation because time will not allow realignment before November 2. Let's hit the field toward that goal.

Robert E. Winslow, M.D.

P.S. We are half way home to our AMA membership goal for 1982. Don't let a day pass without asking a colleague to join — remember, half of all FMA members haven't joined yet!

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Health care in crisis

In June, newspapers across the country splashed headlines across their front pages declaring that physicians were up in arms over the high cost of professional liability insurance. Every major TV and radio station featured interviews with doctors, hospital administrators and others who told the public that physicians could not tolerate skyrocketing premiums. The public sat up and took notice when physicians in Dade and Broward Counties, hardest hit by increases in the Patient's Compensation Fund, vowed to slow down, or even stop performing certain services. Members of the Dade County Medical Association and Broward County Medical Association demanded that something be done about a situation that threatened to put a lot of doctors out of business.

The remedies sought in the special session of the Florida Legislature were a moratorium on future assessments and a freeze on the PCF premiums at the 1981-82 level. Without one of these actions, admonished the doctors, the quality and availability of medical services in Dade and Broward County would diminish, and the costs to the patient would substantially increase.

While not every physician elected to withhold or curtail elective patient care services, some did, and that caused minor cutbacks in hospital services and personnel. However, the problem was not, and is not, local. The entire State of Florida felt the reverberations, even though the premiums are far lower in the remainder of the state than in Dade or Broward.

The public needed to be informed that insurance premiums were rising to unbelievable heights, just to keep pace with an inequitable judicial system, lawyers' contingency fees and excessive jury awards. The backlash meant that many physicians would be restricted from practicing medicine, medical school graduates would not be able to afford to hang up a shingle and the health and welfare of the public would be at the expense of higher and higher hospital and medical charges. Fortunately, the public was given to understand that the crisis affected everyone.

It seems a shame that physicians are forced into such radical action to bring about justly deserved changes. I think it fair to assume that instead of headlines, most physicians would prefer a smooth and orderly transition via tort reform. The idea is

that if physicians can achieve legislative change then, perhaps, the number of non-meritorious malpractice suits will decrease and the size of judgments will be brought back to reality. Following that, insurance premiums would not continue to rise dramatically and health care costs would not increase sharply.

Well, everything sounds good in theory, but once physicians resort to forcing the issues by restricting their services, there have to be certain repercussions. For instance, if surgeons don't operate, the hospital census will fall, employees will be laid off and some facilities may be forced to close. If only emergencies are handled, then some patients may suffer. If a physician stays out of practice for too long a time, he risks a marked decrease in his income, resulting in his inability to pay overhead and living expenses. Finally, public opinion could be forced to turn away from the physician and, when that happens, the cause is lost.

There is a large contingent of physicians who remain diametrically opposed to withholding their services. Whether their reasons be moral or ethical, these physicians feel that there are better ways to accomplish the same goals. They feel that the best leverage we have is found through the unity and strength of local and state medical associations. Through a united approach and a strong public awareness campaign, the severity of this problem can be brought to the forefront.

It is important that we focus on the consequences being thrust upon us and our patients by the professional liability crisis. Under present circumstances, young physicians are preferring to practice in environments more financially suitable than those offered in either Dade or Broward County. Older, established physicians are retiring early, or moving to other states where the PLI problem is not as overwhelming. Although the present crisis resembles an earlier, equally difficult time, many physicians feel that organized medicine has not risen to the challenge. Consequently, the formation of splinter organizations is as much a threat as an unresponsive legislature.

There are proponents of change in the way medicine is practiced who feel that medical liability should be controlled by the federal government. Picking up where now Budget Director David Stockman left off two years ago, Congressman

Richard Gebhardt has proposed legislation known as the "voucher system" concept of medical care. As part of that package, he would like to see a means of controlling professional liability. There is still talk about the establishment of arbitration panels, beginning on the local level and continuing with a forum for appeals up to the national level. Loosely translated, medicine could be facing more federal intervention.

It would be nice if we could return to the 60's, when insurance was reasonable and suits were rare, but that time has come and gone. The intervening years that have brought us to the 80's were not without some measure of sophistication and inevitable complexity. Along the way, we have encountered new problems requiring new alternatives to solve them. There is no question that the present finds us struggling to practice quality medicine at the lowest possible cost in a more litigious environment. The most prudent thing to do, now that the current situation has caught the attention of all those within listening range, is to remain united. Together we can ensure that our interests, and those of our patients, are served for the common good.

A. Frederick Schild, M.D.
Miami



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The Problem

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CLASSICAL INTERSTITIAL CYSTITIS



- ☐ irritative voiding symptoms
- ☐ suprapubic pain
- ☐ functional bladder capacity reduced
- ☐ anatomical bladder capacity:
 - EARLY — normal
 - CLASSICAL — reduced
- ☐ vesical mucosa:
 - EARLY — normal appearing
 - CLASSICAL — ulcerated, scarred
- ☐ submucosal vesical hemorrhages observed following second overdistension

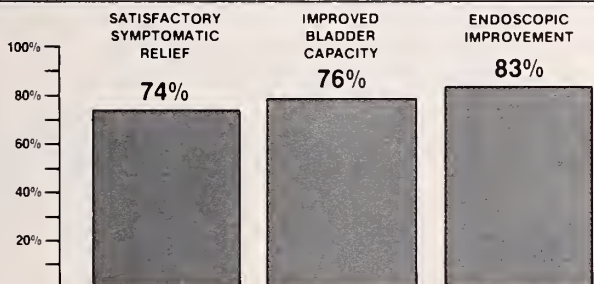
DIAGNOSIS: INTERSTITIAL CYSTITIS

The Solution

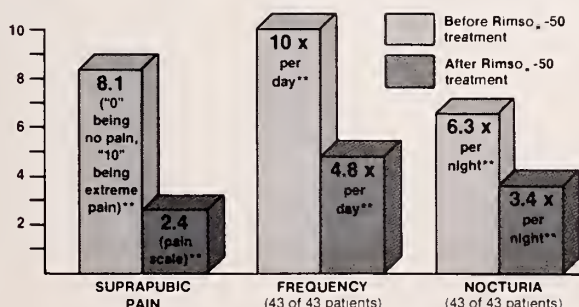


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* (34 of 46 patients) * (31 of 41 patients) * (33 of 40 patients)
* STEWART, B.H., et al., J. Urol., 36:116, 1976



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Rimso-50 (dimethyl sulfoxide) 50% w/w aqueous solution

INDICATIONS AND USAGE: Rimso-50 (dimethyl sulfoxide) is indicated for the symptomatic relief of patients with interstitial cystitis. Rimso-50 has not been approved as being safe and effective for any other indication. There is no clinical evidence of effectiveness of dimethyl sulfoxide in the treatment of bacterial infections of the urinary tract.

CONTRAINDICATIONS: None known.

WARNINGS: Dimethyl sulfoxide can initiate the liberation of histamine and there has been occasional hypersensitivity reaction with topical administration of dimethyl sulfoxide. This hypersensitivity has been reported in one patient receiving intravesical Rimso-50. The physician should be cognizant of this possibility in prescribing Rimso-50. If anaphylactoid symptoms develop, appropriate therapy should be instituted.

PRECAUTIONS: Changes in the refractive index and lens opacities have been seen in monkeys, dogs and rabbits given high doses of dimethyl sulfoxide chronically. Since lens changes were noted in animals, full eye evaluations, including slit lamp examinations, are recommended prior to and periodically during treatment. Approximately every six months patients receiving dimethyl sulfoxide should have a biochemical screening, particularly liver and renal function tests, and complete blood count.

Intravesical instillation of Rimso-50 may be harmful to patients with urinary tract malignancy because of dimethyl sulfoxide-induced vasodilation. Some data indicate that dimethyl sulfoxide potentiates other concomitantly administered medications.

Pregnancy Category C. Dimethyl sulfoxide caused teratogenic responses in hamsters, rats, and mice when administered intraperitoneally at high doses (2.5-12 gm/kg). Oral or topical doses of dimethyl sulfoxide did not cause problems of reproduction in rats, mice and hamsters. Topical doses (5 gm/kg first two days, then 2.5 gm/kg - last eight days) produced terata in rabbits, but in another study, topical doses of 1.1 gm/kg days 3 through 16 of gestation failed to produce any abnormalities. There are no adequate and well controlled studies in pregnant women. Dimethyl sulfoxide should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when dimethyl sulfoxide is administered to a nursing woman.

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: A garlic-like taste may be noted by the patient within a few minutes after instillation of Rimso-50 (dimethyl sulfoxide). This taste may last several hours and because of the presence of metabolites, an odor on the breath and skin may remain for 72 hours.

Transient chemical cystitis has been noted following instillation of dimethyl sulfoxide. The patient may experience moderately severe discomfort on administration. Usually this becomes less prominent with repeated administration.

DOSAGE AND ADMINISTRATION: Instillation of 50 ml of Rimso-50 (dimethyl sulfoxide) directly into the bladder may be accomplished by catheter or aseptic syringe and allowed to remain for 15 minutes. Application of an analgesic lubricant gel such as lidocaine jelly to the urethra is suggested prior to insertion of the catheter to avoid spasm. The medication is expelled by spontaneous voiding. It is recommended that the treatment be repeated every two weeks until maximum symptomatic relief is obtained. Thereafter, time intervals between therapy may be increased appropriately.

Administration of oral analgesic medication or suppositories containing belladonna and opium prior to the instillation of Rimso-50 can reduce bladder spasm.

In patients with severe interstitial cystitis with very sensitive bladders, the initial treatment, and possibly the second and third (depending on patient response) should be done under anesthesia (Saddle block has been suggested).

HOW SUPPLIED:

Bottles contain 50 ml of sterile and pyrogen-free Rimso-50 (50% w/w dimethyl sulfoxide aqueous solution).

Dimethyl sulfoxide is clear and colorless.

Protect from strong light.

Store at room temperature (15° to 30° C).

Do not autoclave.

NDC #0433-0433-05.

*Stewart, B.H., et al., J. Urol., 36:116, 1976

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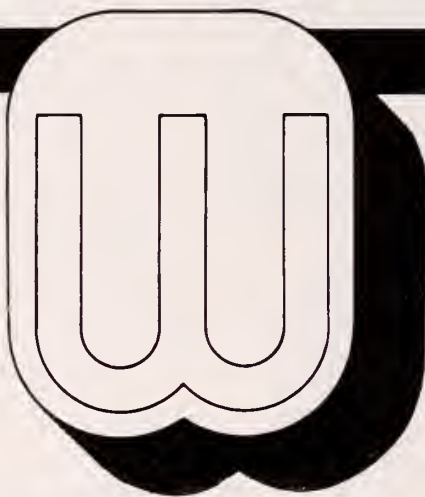
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Balloon embolization of high-flow traumatic arteriovenous fistulae to the brain

J. Parker Mickle, M.D., and Ronald G. Quisling, M.D.

ABSTRACT: Nine patients with traumatic high-flow arteriovenous fistulae involving the carotid and vertebral arteries are presented in detail. Definitive treatment of this entity with detachable balloon embolization was successful in all nine patients. Clinical and technical aspects of this new therapeutic modality are discussed.

High flow carotid-cavernous and vertebro-vertebral fistulae are usually traumatic in origin. These rare vascular lesions present as machine-like bruits in the head following severe trauma to the head or neck. Spontaneous carotid-cavernous fistulae may be high flow or low flow depending on the etiology of the arteriovenous connection. Trauma usually produces a high flow picture with severe ocular involvement and poor filling in the supraclinoid segment of the carotid artery. Attempts to treat these lesions have ranged from proximal ligation of feeding arteries to direct surgical attack of the fistula. The location and clinical manifestations of these lesions are shown in the semi-diagram of Figure I. Standard surgical procedures for these lesions are sometimes ineffective and can be dangerous. Prolo, in 1971 placed an inflatable balloon at a carotid-cavernous fistula site via an internal carotid artery cutdown and left the catheter system in situ after sacrificing the internal carotid artery.¹ This non-detachable balloon technique with open exposure has been utilized several times in our institution with good results. Prolo reported eight cures in twelve cases in 1977 with his technique.² Serbeninko developed a detachable balloon system which could be used to obliterate these fistulae in the neuroradiological suite.³ DeBrun and his colleagues improved the detachable balloon technique, such that the procedure is becoming widely available for the treatment of these difficult and often dangerous lesions.⁴ This report summarizes the technique and our results utilizing the detachable balloon procedure in nine patients over the past two years.

The Authors

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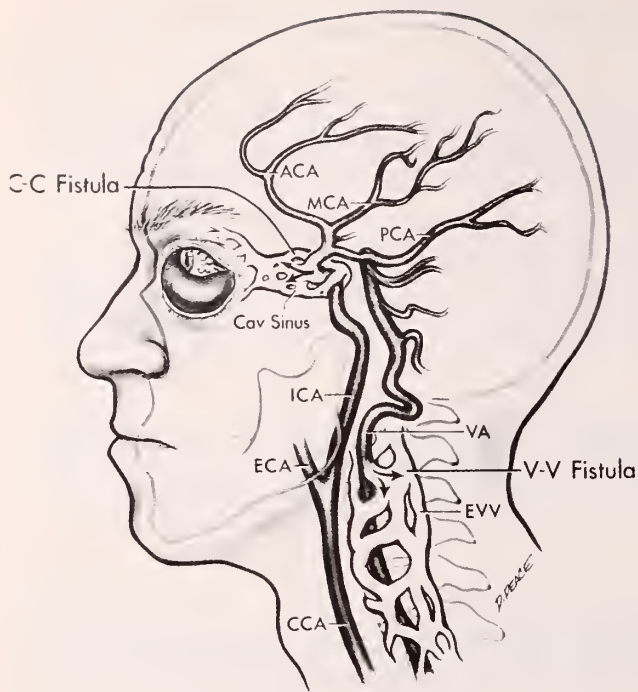


Figure 1—This semi-diagram illustrates the locations of the carotid-cavernous (C-C fistula) and vertebro-vertebral (V-V fistula) fistulae. The ipsilateral eye in C-C fistula is proptotic, chemotic, and pulsatile with scleral edema. The cavernous sinus also transmits cranial nerves three, four, five and six to the eye and face (not shown) which are frequently affected by the fistula producing diplopia, blindness and facial pain. For orientation, the anterior cerebral (ACA), middle cerebral (MCA), posterior cerebral (PCA), internal carotid (ICA), external carotid (ECA), and common carotid (CCA) arteries are shown. A fistula between the vertebral artery (VA) and the epidural vertebral venous plexus (EVV) produces headache and a cranial bruit.

Technical description including catheter-balloon construction • Each patient in this series (Table 1) was treated in the neuroradiology suite without preoperative medication. For the patient with a carotid-cavernous fistula, a 4-vessel high speed cerebral angiogram was accomplished through one femoral artery to define the vascular anatomy of the fistula and brain. The opposite femoral artery was catheterized with the standard DeBrun introducer

and catheter system* (Figure II, A-H). After the appropriate internal carotid artery was entered with the DeBrun balloon catheter system, the smaller coaxial catheter set with attached balloon was advanced into the fistula or into the area of the fistula and inflated with contrast material. When the fistula was shown to be occluded by contralateral angiography and the patient had not shown any detrimental effects of the inflated balloon, the balloon was detached. Figure II demonstrates the steps involved in the balloon construction and detachment. If the procedure required more than one hour to complete, the patient was anticoagulated with 5,000 units of heparin. The anticoagulant effect was reversed each time with 25 mg. of protamine given intravenously over 10 to 20 minutes at the end of the procedure. After each procedure, the patient was placed in the recovery room for one to two hours and then returned to his or her regular hospital bed for continued observation for one to two days. For the patient with a vertebro-vertebral fistula only one femoral artery was utilized for angiography and embolization. Otherwise, the steps are the same as for the carotid-cavernous fistula.

The criteria we use to define a successful embolization are: (1) no identifiable fistula on angiography after embolization, (2) disappearance of the bruit based on patient report and Doppler testing, (3) clinical improvement in the ipsilateral chemosis and proptosis after balloon embolization for carotid-cavernous fistula.

Clinical material • Two cases with fistulae are presented in detail with X-rays to better illustrate our techniques as compared to others in this field. A summary of all the patients, including follow-up, is shown in Table 1.

Patient C.W. is a 36 year old female who was well until six months prior to admission to the University of Florida Medical Center for a bruit in the left side of the head, proptosis and chemosis of

*Ingenor, 70 Rue Orfila, 75020 Paris

TABLE 1
Nine Cases of Traumatic Carotid-Cavernous (7)
and Vertebro-Vertebral (2) Fistulae Treated
with Balloon Embolization (1980-81)

Type Fistula	#Cases	Etiology	Average Time for Balloon Embolization	Fistula Obliterated	Complications	Follow-up in Months (Range)
Carotid-Cavernous	7	Blunt Trauma-6 Gunshot Wound-1	2h*	7	0	3-26
Vertebro-Vertebral	2	Blunt Trauma-1 Knife Wound-1	1h*	2	0	23-26

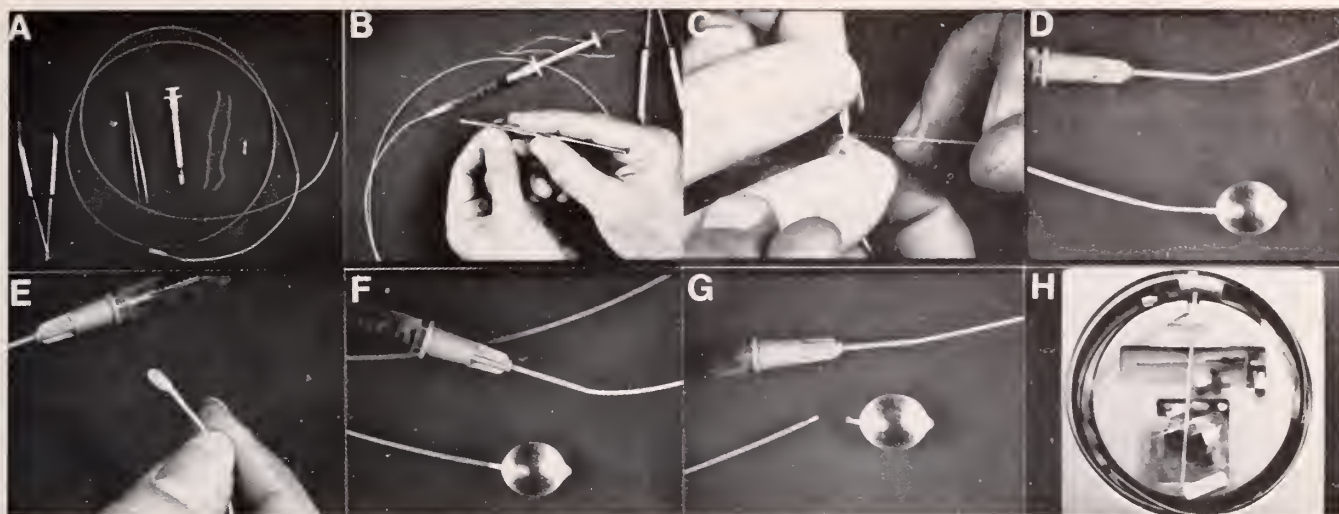


Figure II—This composite photograph depicts the principle steps in the construction and detachment in the balloon embolization technique (A-G). A standard DeBrun embolization set is shown in (H). The standard DeBrun set contains a large bore catheter for introducing the coaxial catheter-balloon into the carotid artery. The devices required for construction are shown in (A). The balloon is worked onto the small inner catheter (B) and secured with a latex tie (C). The balloon is inflated with contrast (D), and can be easily deflated with the attached syringe (E). Once the balloon is situated through the fistula, the blue outer catheter is advanced to engage the balloon cuff (F). A steady pull on the white catheter will detach the balloon (G).

the left eye, and diplopia. Six months prior to this admission, she had struck her head secondary to a fall on descending a staircase. Shortly after that fall, all the symptoms appeared except the diplopia. When she noted double vision, she was referred to the University of Florida for evaluation.

On physical examination she had marked proptosis and chemosis of the left eye with a very loud machine-like murmur heard best over the left temporal and left supraorbital regions (Figure III-A). She also demonstrated a nearly complete left sixth nerve palsy, and complained of intermittent severe pain behind the left eye. Angiography (Figure IV-A) demonstrated a large carotid-cavernous fistula with marked venous engorgement, especially involving the left orbit. Without sedation, she was taken to

the neuroradiology suite, and with the techniques described for Catheter-Balloon Construction, underwent balloon embolization of the carotid-cavernous fistula. Figure IV-B and C demonstrate the indwelling three balloons filled with contrast material, obliterating completely the fistula. The left cerebral circulation is derived primarily from the right carotid circuit filling readily through a patent anterior communicating artery (Figure IV-D). Post-embolization, the proptosis, chemosis, left sixth nerve palsy and bruit disappeared. These symptoms resolved within 30 minutes of the embolization, and she was returned to her regular hospital bed for continued observation. She remained well and was discharged from the hospital two days after the embolization, with mild left-sided headaches persisting

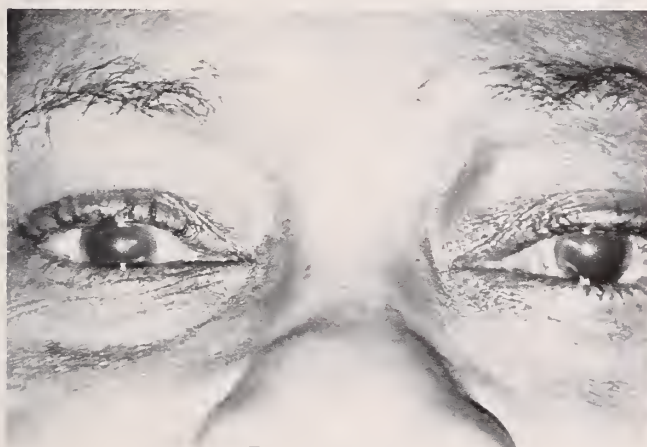


Figure III—These photographs show the ocular findings in patient C.W., pre-embolization (A) and post-embolization (B). The left chemosis, proptosis, ocular pulsations and diplopia resolved within hours after the operation. The post-embolization photograph was taken two weeks after the embolization.

for two months. Follow-up 18 months later demonstrated no evidence of persistent fistula.

later showed no evidence of persistent fistula. The patient was asymptomatic. Table 1 summarizes our experience with the detachable balloon techniques for the control of high flow arteriovenous fistulae.

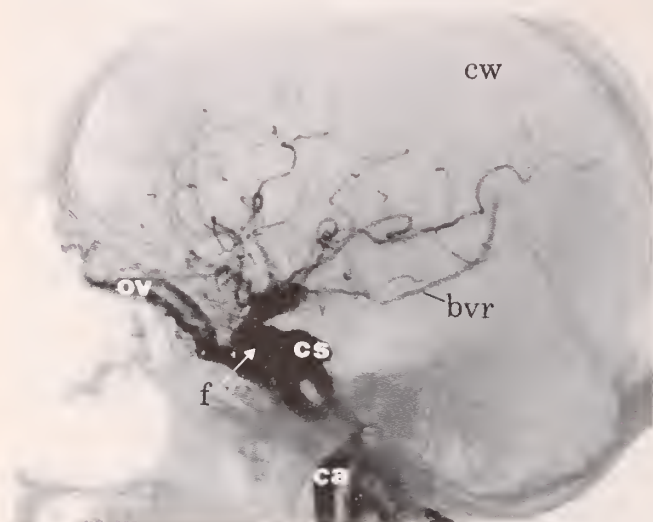


Figure IV-A—Subtracted lateral, arterial phase, left cerebral angiogram demonstrates rapid shunting from the carotid artery (CA) through a post-traumatic fistula (F) into the cavernous sinus (CS). The high pressure, high flow shunt forces contrast media into the superior ophthalmic veins (OV), and the basal vein of Rosenthal (BVR). This carotid-cavernous fistula results in an incomplete cerebral steal, since contrast is able to opacify most of the left middle cerebral artery circulation.

Patient C.J. is a 24 year old male admitted to our neurosurgery service for evaluation two years after being stabbed in the right side of the neck. Shortly after the stab wound, the patient noted a machine-like murmur in the right side of the neck radiating into the right side of the head. This was accompanied by pain in the neck and venous distention with swelling in the right side of the neck. Over the subsequent two years, he was seen by multiple physicians, and underwent many sets of angiograms. Figure V-A and B demonstrate the anatomical cause of his complaints. After two unsuccessful surgical exposures of this lesion, he was referred to the University of Florida for balloon embolization. His physical examination then was significant in that he had several surgical scars over the right side of his neck. His right neck was swollen, with marked venous engorgement, with a pansystolic murmur over the entire neck radiating to the right posterior fossa. He was taken to the neuroradiology suite and under local anesthesia underwent placement of a large DeBrun balloon on the venous side of the fistula, which was completely obliterated with inflation of the balloon with contrast material. The balloon was detached, and the postoperative angiogram is demonstrated in Figure V-C. Postoperatively, the patient had no complications, and was discharged from the hospital one day after his embolization. Return evaluation 21 months

Discussion • The cavernous sinuses at the base of the skull are unique in that the large carotid arteries and their branches pass directly through these venous structures. Also cranial nerves three, four, five and six run in or through the sinuses on their way to the eyes and face. The carotid artery enters the sinus after leaving the petrous bone. In addition, the cavernous sinus and the cavernous portion of the carotid artery are located at the base of the skull in the medial portion of the middle cranial fossa. In this location, they are subject to injury from penetrating wounds of the skull, and more commonly, after basilar skull fractures. As a result of a tear in this part of the carotid artery or one of its branches arterial blood can pass directly into the cavernous sinus to produce the carotid-cavernous fistula syndrome. Normally, the cavernous sinus receives the venous drainage from the eye, the dura of the middle cranial fossa, part of the cerebral cortex via the Sylvian vein, and the opposite cavernous sinus through the circular sinus. The efferent drainage of the cavernous sinus is posterior through the superior and inferior petrosal sinuses to the jugular bulb. The clinical picture defined in the carotid-cavernous



Figure IV-B—Lateral, cranial radiograph demonstrates the presence of three contrast-filled, DeBrun type intraarterial balloons (arrow). Each has a silver tip, which is used to identify the balloon position after the contrast media has resorbed. The middle balloon is positioned within the fistula proper, while the other balloons have been placed immediately proximal and distal to the fistula site within the carotid artery. This insures the fistula will not persist from either orthograde or retrograde filling of the cavernous segment of the carotid artery.

fistula syndrome is largely dependent upon the predominant venous outflow affected by the fistula. Since the superior ophthalmic vein has no valves and no dural support, it is the path of least resistance for the arterial blood and produces most of the signs in carotid-cavernous fistulae.

Clinically, the patient is most aware of a loud bruit in the head. This distressing syndrome is worse at night when reclining and with the head dependent. The murmur is easily heard with a stethoscope over the eye and skull. Although both eyes may be affected, more commonly the ipsilateral eye is more proptotic, chemotic, and pulsatile (Figure III-A). This striking appearance is caused by the distended, tense veins of the orbit. The sixth, third and fourth cranial nerves may be affected to produce diplopia. Facial pain and headache are usually present and may be severe. Loss of vision may occur and is thought to result from retinal hypoxia secondary to the tremendous increase in venous pressure.⁵ Life threatening complications such as exsanguination from epistaxis and intracranial hemorrhage have been reported but are rare.⁶ Although spontaneous remission of symptoms may occur, most patients eventually seek intervention because of cosmetic appearance, bruit, pain or headache and decreasing visual acuity. If signs and symptoms are mild, the syndrome may be overlooked for months following severe head injury. Etiologically, trauma is the most common cause of the carotid-cavernous fistula. When a case is spontaneous in onset, rupture of a pre-existing intracavernous carotid artery aneurysm is usually implicated as the cause. Traumatic fistulae and those caused by rupture of an aneurysm are high flow fistulae as defined by angiography and rarely spontaneously resolve. Low flow fistulous states producing this syndrome tend to occur in middle aged females with dural arteriovenous malformations and often resolve spontaneously.

The classic carotid-cavernous fistula picture is easily differentiated from other pathologic entities about the orbit. Proptosis secondary to orbital tumors, endocrinopathies, and pseudotumor are not pulsatile and there is no bruit. Disruption of the posterior wall of the orbit due to trauma, tumor growth, and with certain congenital anomalies (neurofibromatosis) may produce a pulsating exophthalmos but without bruit. Orbital arteriovenous malformations may produce a syndrome indistinguishable from carotid-cavernous fistulae except by angiography.

The definitive diagnostic test for carotid-cavernous fistula is four vessel cerebral angiography through a femoral approach. A complete study is necessary for the following reasons: to define (1) the size and exact location of the fistula, (2) the relationship of the fistula blood supply to that of the brain,

(3) the existence of collateral blood supply to the brain and fistula, (4) anomalies of the circle of Willis, (5) venous drainage patterns, and for defining (6) atypical blood supply from the external carotid arteries. Also, if other forms of therapy have preceded balloon embolization, angiography can be extremely helpful in planning the appropriate interventional approach.

Since spontaneous resolution of the high flow carotid-cavernous fistula is rare, most patients eventually seek some form of intervention. Generally, these high flow fistulae are not life-threatening and therapy must strive to eliminate the clinical syndrome without causing cerebral ischemia or cranial nerve palsies.

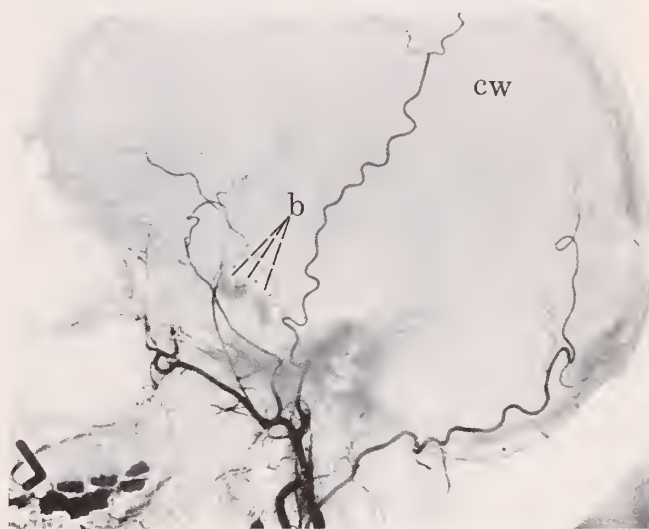


Figure IV-C—Subtracted lateral, left common carotid angiogram demonstrates opacification of the left external carotid distribution. Blood flow through the left internal carotid artery has been eradicated by the placement of the detached intraluminal balloons (B).

Common or internal carotid ligation in the neck alone is unsuccessful and dangerous. In this situation the fistulous demands are met by the many collaterals at the base of the brain, and blood is "stolen" from the brain. For this reason, Hamby, Gardner, and Dandy utilized the so-called "trapping" procedure where the intracranial internal carotid artery above the fistula is ligated via craniotomy initially followed by ligation of the carotid artery in the neck.^{7,9} This extensive procedure produces a "cure" in as many as 90% of cases.¹⁰ Brooks embolized a strip of muscle to the fistula via the internal carotid artery.¹¹ Arutinov developed a variation of this embolic scheme making the procedure more selective and therefore safer.¹² Trapping combined with controlled embolization of a muscle stamp was introduced by Jaeger.¹³ Surgically, this seems to be the safest and most reliable procedure.¹⁰ Other embolic materials such as gelfoam and porcelain beads have been used

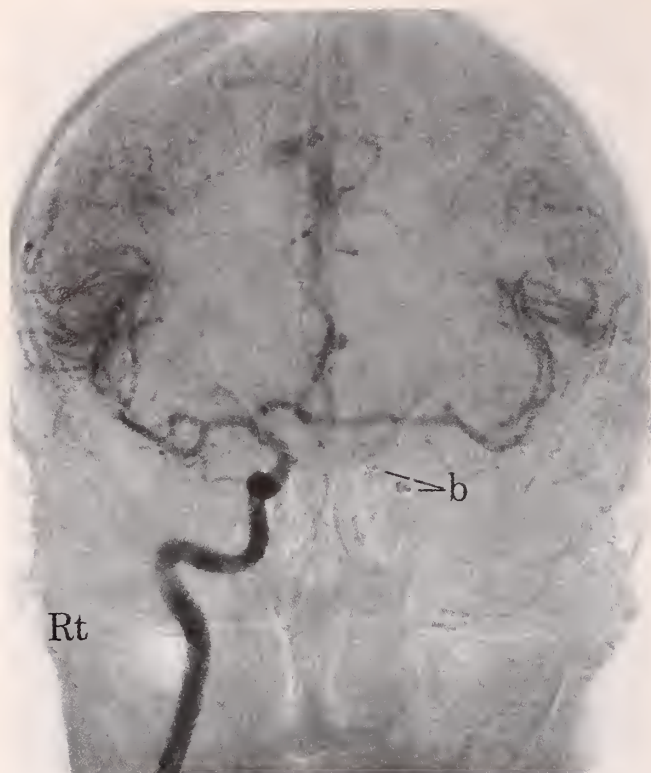


Figure IV-D—Subtracted AP, right carotid angiogram demonstrates the opacification of the cerebral circulation for both right and left middle anterior cerebral arteries. The silver clips on the DeBrun (B) balloons are evident despite the subtraction techniques. No retrograde filling of the carotid-cavernous fistula is evident.

and largely discarded. Parkinson studied the anatomy of the cavernous sinus and concluded a direct approach to the carotid-cavernous fistula could be made.¹⁴ However, deep hypothermia and cardiac arrest are necessary for success in this procedure. Mullan reported excellent results in 31 cases using thrombogenic wire passed into the cavernous sinus transvenously via craniotomy.¹⁵ Parkinson and Mullan were often able to maintain patency of the cavernous carotid artery. Prolo developed a nondetachable balloon system which could be introduced and secured in the cervical internal carotid artery.^{1,2} Eight of his twelve patients had excellent results. Excepting the reports of Parkinson and Mullan above, all the other techniques thus far examined are ablative of the carotid artery. Stern reported serious cerebral ischemic complications in four of fifteen cases thus treated.¹⁶ This knowledge led to the development of a detachable balloon system by Serbeninko.³ DeBrun has made this approach popular and accessible.⁴ The balloon is flow directed through the fistula and inflated with contrast material or a permanent silicone polymer. His recent summary of 54 cases is impressive. DeBrun is able to maintain carotid artery patency in over 50%

of cases. The most common complication reported by this author was the presence of a venous pouch in 44% of cases. Other cranial nerves were less often affected. Cerebral ischemia was rare. In none of our cases were we able to maintain carotid artery patency. In three of the cases we were able to enter the fistula easily with the flow directed balloon but produced significant cranial nerve deficits with inflation. With more experience and smaller balloons we feel confident that a high patency rate of the carotid artery is possible. We have had no cerebral ischemic episodes. We have not elected to re-angiogram our patients if they are asymptomatic on follow-up.

The vertebral arteries have a long course in the neck after their origins from the subclavian arteries. They run in the foramina transversaria of each cervical vertebra above C7. A high flow arteriovenous fistula of this artery can be congenital, but more commonly traumatic in origin. The congenital lesions are present from birth and occur at the C1-2 level. Severe closed trauma or penetrating injuries to the neck are the most common causes of this high flow fistulous state. The vertebral artery may also be injured during various surgical procedures to produce the syndrome. The venous component of this fistula may be the spinal epidural venous plexus or internal jugular vein (Figure I). As with carotid-cavernous fistula, the vertebro-vertebral fistula is suspected weeks to months after the injury. The patient complains of a constant murmur in the neck and head and occasionally pain in the same locations. On physical examination, the soft tissues of the neck are prominent on the side of the fistula and the veins are distended. There is a bruit over the neck radiating into the head posteriorly. The neurological examination is usually normal. The history and physical examination is specific for this disease entity. Certain vascular tumors and congenital arteriovenous malformations in the neck may be difficult to exclude, except with angiography, the definitive diagnostic test (Figure V).

Surgical management of vertebro-vertebral fistula has a long and interesting history. Since the lesion is rare, no one center has reported extensive experience in the therapy of this vascular lesion. The surgical goal was to eliminate the fistula by a direct approach or by trapping. As in our patient C.J., the direct approach was often unsuccessful.¹⁷ Through a femoral approach, the fistula is eliminated in over 90% of cases while maintaining patency of the vertebral artery in almost all patients. Our two cases were handled in the standard way with complete obliteration of the fistulae and no complications. Again, we have not re-angiogrammed our patients in follow-up, since they were asymptomatic without evidence of persistent fistula.



Figure V-A—Subtracted AP, arterial phase, right vertebral anglogram demonstrates the nearly simultaneous opacification of the right vertebral artery (VA) and the paravertebral venous plexus (VV). The vertebral artery—vertebral vein fistula (F) has resulted in the formation of a large "venous aneurysm" (An). Such rapid opacification of both arterial and venous structures is indicative of a high flow, high pressure arteriovenous shunt.

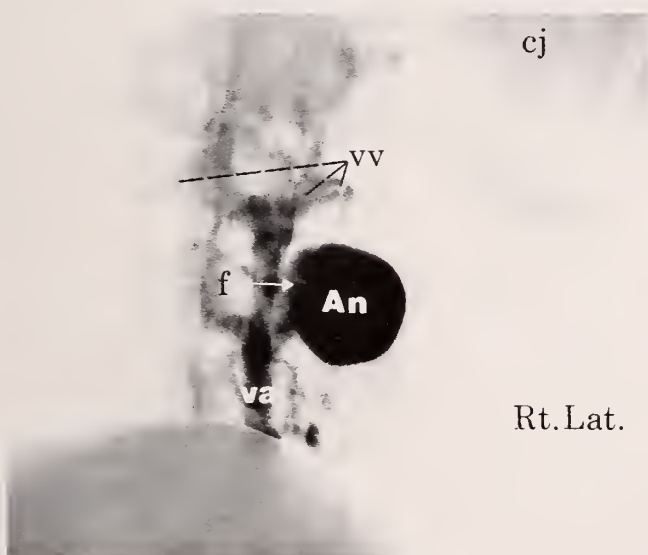


Figure V-B—Subtracted lateral, arterial phase, right vertebral anglogram demonstrates the relationship of the vertebral artery (VA) high flow fistula (F) to the "venous aneurysm" (An) and the paravertebral venous plexus (VV). This fistula is near the C₃-C₄ level of the spine.

Carotid-cavernous and vertebro-vertebral fistulae are rare vascular lesions which are usually

caused by trauma to the head and neck. The syndromes produced by these lesions are well defined and easily differentiated from other disease entities by carotid and vertebral angiography. The elimination of these high flow fistulae with the new techniques of balloon embolization yields excellent results as compared to the best surgical results. The technique is relatively simple after familiarity with the materials is mastered in a laboratory setting. The average time for embolization in our patients was 1.5 hours, and the average hospital stay was three days. We have been unable to maintain carotid artery patency without producing cranial nerve deficits. Thus far in this small number of patients no ischemic deficits have resulted. We feel this new and exciting technique is a major advance in the treatment of these difficult lesions and will become more easily accessible to the clinician in the future.

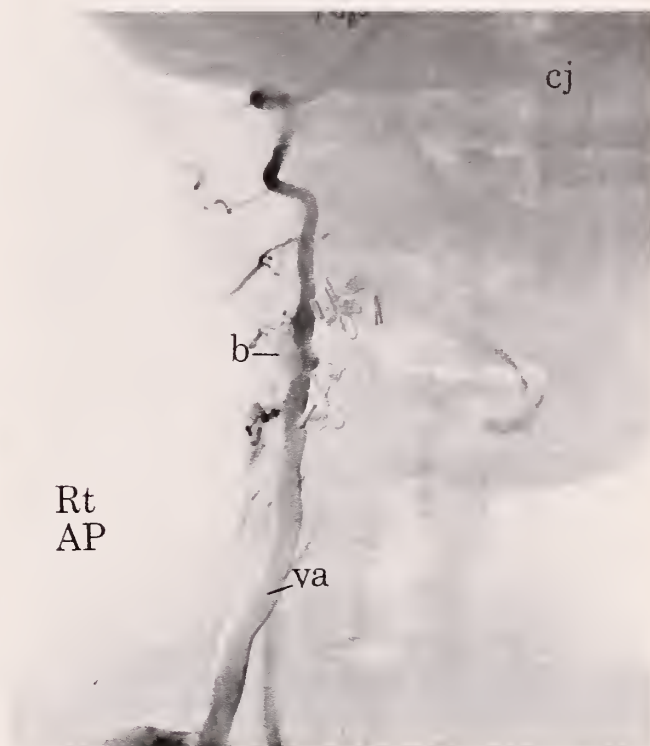


Figure V-C—Subtracted AP, arterial phase, right vertebral anglogram demonstrates the complete eradication of the vertebral artery-vertebral vein fistula. The vertebral artery (VA) has a normal appearance and clearance rate, while demonstrating only a mild stenosis at the balloon (B) site. The surgical clips are the sequelae of previous unsuccessful operative attempts to control this fistula.

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Hemolytic anemia and prosthetic heart valves

Neil Abramson, M.D.

ABSTRACT: Hemolytic anemia associated with prosthetic heart valves has been documented since 1954. The incidence of this disorder varies depending upon the laboratory tests that are utilized to make the diagnosis. Hemolysis occurs more with aortic valve prostheses than with mitral valve and occurs more frequently with synthetic valves than with tissue valves. Since patients hemolyze they may need to receive folic acid and iron. Replacement of the valve for hemodynamic considerations will usually abate the hemolysis; however, hemolysis alone should not be the reason for surgical replacement.

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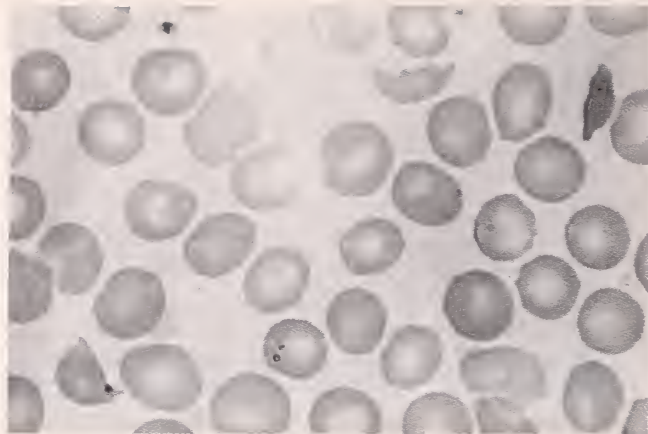
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In this past century, numerous disease states have been associated with fragmentation of red cells (Fig. 1) and more recently referred to as traumatic hemolytic anemia. The best example and the clearest demonstration of traumatic hemolytic anemia is that which is seen with artificial valves, an entity which was described first by Rose and Hufnagel in 1954.¹ All of the blood volume eventually traverses past the small orifices of heart valves, hence, it is likely that any altered anatomy of the valves would potentially have a profound effect on red cells. The late Dr. Fred Stohlman confirmed the initial observation of Rose and Hufnagel on prosthetic valve associated hemolysis²; however, none of these investigators commented upon the red cell morphology.

It was not until ten years later that Sayed and Dacie published their report in the thoracic literature that fragmentation of red cells was described.³ Though the emphasis in this review will be on traumatic hemolysis with prosthetic valves, numerous other disorders of the vessels are associated with the same pathophysiologic changes; that is, fragmented red cells have been seen in intracardiac defects patched with foreign material in which endothelialization has not yet taken place, coarction of the aorta, aneurysms of saccular and dissecting varieties, valvular heart disease per se without prosthetic replacement, and synthetic aortic grafts.

Underlying pathophysiologic mechanisms • The pathophysiologic mechanisms underlying traumatic hemolytic anemia can be divided into four categories: (1) immune destruction, (2) mechanical trauma, (3) turbulence and (4) deposition of platelet-fibrin material.



Photomicrograph of peripheral blood smear of patient with prosthetic valve and hemolysis. Distorted and fragmented red cells in this setting suggest traumatic hemolytic anemia.

Immune factors have been suggested as mediators of red cell destruction with heart valves because of the occasional case of a patient with a positive Coombs test.⁴ It has been suggested that trauma to red cells permits the exposure of subsurface antigens to which an immunologic response occurs. This mechanism though seems unlikely as a common cause for hemolysis because red cells destroyed by an immunologic mechanism, such as by IgG, would do so by splenomegaly and spherocytosis, both of which are uncommon findings with prosthetic valves. In addition, the presence of antibodies is infrequent with prosthetic valves but when antibodies are found, they are either antigen-specific suggesting prior transfusions or they are panagglutinins, antibodies which are unlikely to be present if subsurface antigens are exposed on only some red cells.

The second mechanism, blunt mechanical trauma of red cells as they impact upon artificial valves, must be strongly considered as an etiology especially if one makes analogies to traumatic hemolysis which has been seen in March hemoglobinuria,⁵ marathon running, karate,⁶ or with the use of bongo drums.⁷ Direct trauma is undoubtedly one of the important mechanisms underlying fragmentation; however, it cannot be the only factor since more instances exist in which valves are present without hemolysis than with. Trauma to the cells though may occur simply by the exposure of red cells to the synthetic material or the artificial surfaces of prosthetic valves. Support for this is provided by the occasional case report of hemolysis present when teflon, dacron or gortex material is implanted and left exposed.^{8, 9} After endothelialization of the synthetic material, hemolysis abates.

The third etiologic factor, turbulence, is one of hemodynamics. Prosthetic valves may cause extreme abnormalities in blood flow. That turbulence is an important factor is now known because of the

descriptions which appeared after the initial discoveries of prosthetic valve hemolysis in which hemolytic anemia was reported with valvular heart disease per se in the absence of artificial valves¹⁰. An inflexible aortic valve across which high pressures and increased flow rates occur has been well-described to be associated with the identical features of traumatic hemolytic anemia. Though less commonly seen because of lower pressures and lower flow rates across an inflexible mitral valve, mitral valve disease also causes hemolysis. In addition, turbulence may suddenly occur when leaks appear at the attachment sites of prosthetic valves or when variance of the ball occurs within the valve cage, or when minor defects are present in the ventricular or atrial septa. When turbulence is corrected, by whatever means, accelerated hemolysis is reversed.

Lastly, the deposition of platelet-fibrin complexes upon valves must be included as a pathophysiologic mechanism. The relationship of clottable material to microangiopathic hemolytic anemia has been well-established especially with the elegant in vitro demonstrations by Brain et al of fragmentation as red cells are forced through fibrin mesh.¹¹ Platelet consumption and thromboembolic disease are oftentimes complications of prosthetic heart valves; hence, an association between coagulum and fragmented red cells is a natural one.

Incidence of traumatic hemolytic anemia • An estimation of the incidence of traumatic hemolytic anemia associated with prosthetic valves is most difficult to determine because it depends in part on the hemodynamic situation of the individual patient and more greatly on the tests that are utilized to document the presence or absence of hemolysis. Reticulocytosis with or without anemia is not a common feature; in fact, in one study 30 percent of patients with hemolysis as determined by radioisotope studies had reticulocyte counts less than four percent. The liberation of free hemoglobin from red cells is associated with the depletion of haptoglobin and in most studies the lowering of haptoglobin correlates closely with actual evidence of traumatic hemolysis. Hemoglobinuria is an insensitive laboratory test since a great degree of hemolysis must occur in order to exceed haptoglobin binding and to escape the proximal tubular resorptive capacity for hemoglobin. On the other hand, hemosiderinuria, the presence of iron in proximal tubule cells that have been extruded into the urine or the presence of free hemosiderin in the urine is a much more common feature of traumatic hemolysis. Some studies have utilized LDH determinations or isoenzymes of LDH; however, LDH functions as a non-specific acute phase reactant and

though LDH is sensitive it is non-specific. Recognition of red cell abnormalities by microscopic review is unreliable as well. The blood smear seen with traumatic hemolytic anemia is inconsistent. Most commonly, the anemia is normocytic and normochromic, but at times, enough iron is lost via the kidneys that hypochromia and microcytosis is seen. Also at times, a relative folic acid deficiency occurs in which case macrocytosis is present. The actual appearance of fragmented red cells on peripheral smears such as the one illustrated in Fig. 1 is infrequent; when present, however, hemolysis is very likely, but the absence of fragmentation does not rule out hemolysis. Thus, if one relies on fragmented cells, reticulocytosis, hemosiderin in the urine and a haptoglobin abnormality, then the incidence of traumatic hemolytic anemia with prosthetic valves can be as low as five percent. On the other hand, if one would rely solely on a highly sensitive though non-specific test, such as LDH determinations, then one might find that the incidence of hemolysis would be as high as 91 percent as reported in one study.¹² Clearly the most reliable method for estimating incidence is by radioisotopic red cell survivals,¹³ but time, cost, and inconvenience are factors which mitigate against its common use.

The type of valve utilized strongly correlates with the frequency of hemolytic anemia. The Starr-Edwards valve (caged valve) has a relatively high incidence of hemolysis as does the Bjork-Shiley valve (tilting disc). Both of these prostheses contain artificial, synthetic or non-biologic materials. Hemolysis may occur because of turbulence or direct mechanical trauma or because of lack of endothelialization over the synthetic material. The St. Jude's valve has not had enough of a clinical trial for estimation of frequency of hemolysis. Tissue valves such as porcine and bovine varieties have a lesser incidence of hemolytic anemia than prosthetic valves. Eventually these valves endothelialize as well and hemolysis has been described late when fibrous tissue and calcification have occurred on these valves, causing stiffness and increased turbulence.¹⁴

Synthetic valves have a higher incidence of platelet-fibrin complexes, platelet consumption, and thromboembolic disease as compared to porcine or bovine tissue valves. In terms of thromboembolic disease, it is felt that when endothelialization occurs about the synthetic material or about the tissue then the incidence of thromboembolism decreases; however, fibrous tissue and calcification may follow endothelialization, thereby predisposing to coagulation abnormalities and hemolysis once again. The new St. Jude's valve is claimed to be associated with less thromboembolic disease.

Finally, a comment must be made on treatment of traumatic hemolytic anemia associated with prosthetic valves. Correction of valve architectural

abnormalities, regardless of the type of defect, should correct accelerated hemolysis. However, hemolysis is not, in and of itself, an abnormality which occurs in such severity that valve replacement is entertained. Onset of traumatic hemolysis may sometimes be the first clue to some underlying hemodynamic abnormality. In addition, it must be remembered that the presence of chronic hemolytic anemia is not damaging to the host with the possible exception of chronic hemosiderin deposition in renal tubule cells. There are no substantive reports or autopsy studies in the literature in which renal hemosiderosis was present to the degree that renal failure comprised the host. While on the subject of urinary iron loss, it must be noted that hypochromic and microcytic red cells are thought to be mechanically more fragile and therefore, may be more likely to undergo premature destruction. Hence, oral iron therapy should be utilized especially when evidence of renal iron loss exists. In some studies, iron replacement corrects some of the anemia but very little of the hemolysis. Betablockers are suggested by some as therapy for hemolysis. These agents perhaps work by slowing heart rate and reducing peak flow rates across valves. Finally, another therapeutic possibility has been suggested by an interesting paper which has recently appeared in the Canadian literature.¹⁵ In that report, three patients were treated with sulfapyrazone for thromboembolic disease. Hemolytic anemia which had been present previously lessened considerably with sulfapyrazone treatment. This report should not initiate widespread use of sulfapyrazone for valve associated hemolysis since tens of thousands of patients with prosthetic valves have already been treated with anticoagulants or with anti-platelet compounds in the past and no other reports have appeared suggesting that hemolysis may be corrected by such treatment.

Summary • Traumatic hemolytic anemia associated with prosthetic valves is perhaps a common phenomenon, but the incidence is difficult to assess and depends greatly upon the sensitivity of the tests utilized. When hemolysis occurs, it does so with greater frequency over aortic valves than mitral and with prosthetic valves of synthetic material than with tissue valves. To recommend the use of tissue valves over synthetic valves solely for a lessening of hemolytic anemia would be foolhardy since valve performance and hemodynamic factors far outweigh the hazards of traumatic hemolytic anemia. Iron therapy when appropriate and folic acid treatment when necessary should be given since any improvement in hemoglobin level can only improve oxygen transport and cardiovascular function. Though a rare individual may experience severe hemolysis

such that valve replacement is contemplated, it is unlikely that such hemolysis would occur without concomitant para-valvular leaks or hemodynamic abnormalities. Surgical decisions on valve replacement should be made by cardiologists rather than by hematologists.

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Habilitation of patients with severe facial deformity by corrective cranio-orbital surgery

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ABSTRACT: *For centuries the predominant treatment for children born with major facial deformities and no other functional abnormalities was concentrated upon naming the syndrome. Some of these patients with normal mental ability now reside in retardation institutions and over the years mental deprivation syndromes have developed.*

During World War II experience in operating on casualties with major facial disfigurements directed attention to children with facial deformities. The complexity of these procedures make it impossible for this surgery to be practiced in all hospitals but a dozen centers provide the procedures and also rehabilitative programs for selected patients. The anatomic problem of hypertelorism and lack of fusion is being remedied by moving the orbits together. Shallow orbits in exorbitism are corrected by moving the orbits forward. Patients with disfigurement from tumor resection or trauma are offered better methods of rehabilitation. Progressively, younger patients are being selected. Potential complications related to brain edema are avoided by preventive measures and careful monitoring during the operative procedures.

Our experience with more than 150 patients with long-term follow-up is presented.

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Based upon presentation of a scientific exhibit at the 108th Annual Meeting of the Florida Medical Association, Hollywood, May 5-9, 1982.

For centuries children born with major complex facial deformities without any other functional abnormalities had predominant management focused upon giving a name to the clinical problems. Syndrome identification was the end of the treatment plan. Occasionally soft tissue camouflage operations were described, but results were temporary and incomplete. The reason for such approach was based upon two factors: (1) Most complex facial deformities are skeletal in origin. (2) Our knowledge of operating on the facial skeleton in the cranio-orbital region was incomplete. Recent advances have promoted a new frontier in pediatric plastic surgery.^{1,2} Craniofacial surgery has been given a fresh perspective and advances are continuously being made.

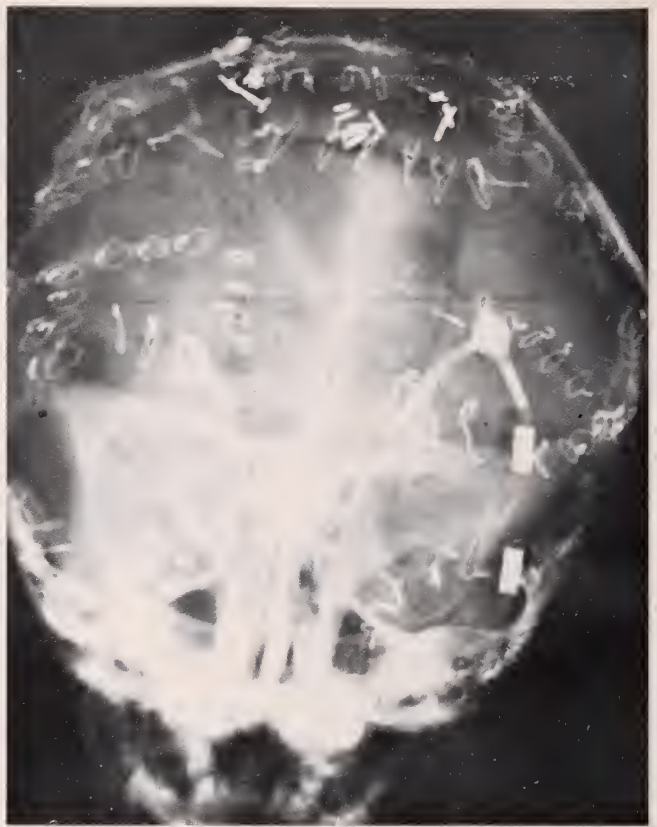
Operative maneuvers limited to the upper part of the face and the basal part of the skull are referred to as cranio-orbital surgery when the focus of attention and correction is on and around the orbits.^{3,4}

Cranio-orbital operative procedures are complex and time-consuming and their performance has been limited to about two dozen centers in the United States,⁵ Europe and the Far East. By definition, over 50 major craniofacial operations are performed in these centers each year. This life frequency is an important factor in minimizing complications, improving results, and maintaining the skill of the team members.

Careful thought is a prerequisite for adequate preoperative planning so that all strategies needed for the operative procedure can be considered. Today extensive operative procedures are limited only by the basal structures of the skull and the imagination of the operating surgeons.



Fig. 1—A. Preoperative radiograph of a patient with severe hydrocephalus.



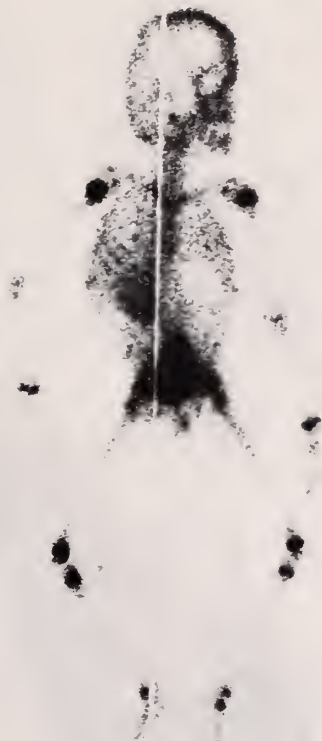
B. Postoperative radiograph to demonstrate major reduction in size of the head and change in shape. Note the interosseous wiring.



C. Intraoperative view to show the importance of appropriate fixation when working on the bony structures in the head.



D. Intraoperative view to demonstrate the change in the anterior inclination of the forehead and the upper part of the orbits. Note the complete fixation.



E. Postoperative Tc99 scan to demonstrate the cranial viability of the cranial bone structure.

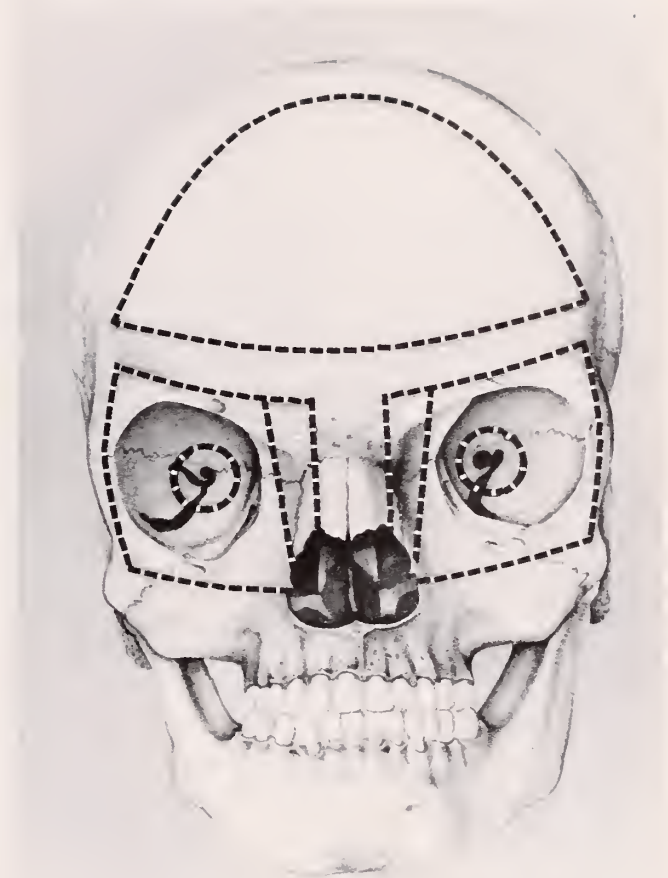
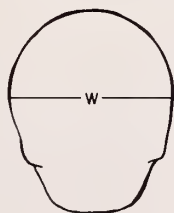
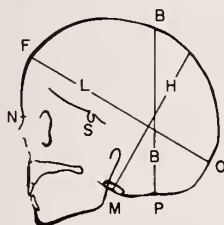


Fig. 2—An outline of the major osteotomies in the facial bones for the correction of hypertelorism.

Cranial Volumetrics

$$V = \left(\left[(L \times W \times B) + (L \times W \times H) \right] \times 0.1594 - 30/100^* \right) \pm 2.4/100^{**}$$

	Measurements From Radiographs cm.				Neurocranial Volume cm ³		
	L	W	H	B	V	E	
Patient Preop.	> 28.5	22.0	24.5	26.3	3554.0	± 85.3	63.24% Reduction
Patient Postop.	> 19.4	17.0	16.5	19.0	1306.4	± 31.3	
Normal Subject	> 19.3	16.5	14.5	17.2	1126.4	± 27.0	



*Radiograph Magnification = 30 %
**Error Rate 2.4%

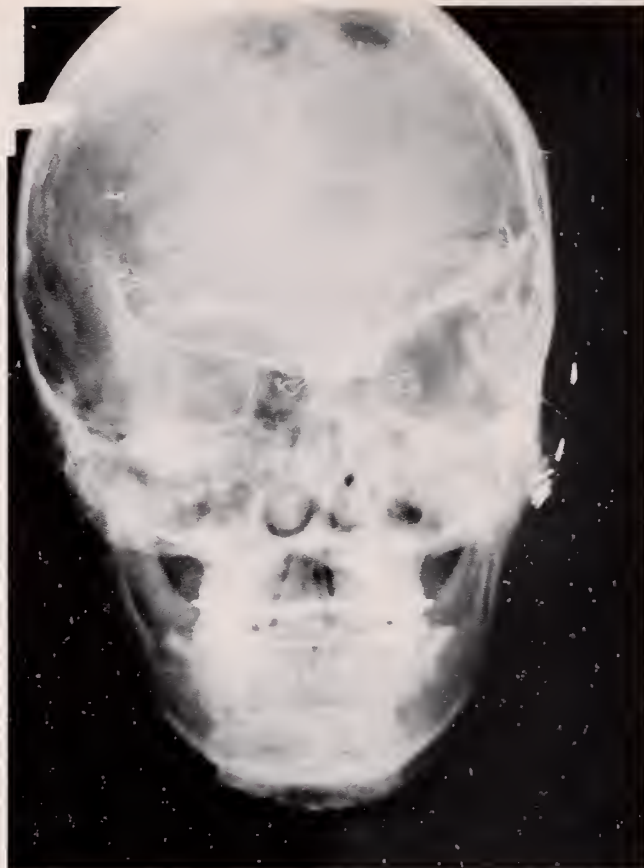
F. An outline of the cranial volumetric change.



Fig. 3—A. A photographic view of the patient before (above) and after (below) cranio-orbital correction of hypertelorism.



B. Preoperative radiograph. Note the wide distance between the orbits.



C. Postoperative radiograph. Notice the lines of the osteotomies and the intraosseous wiring.

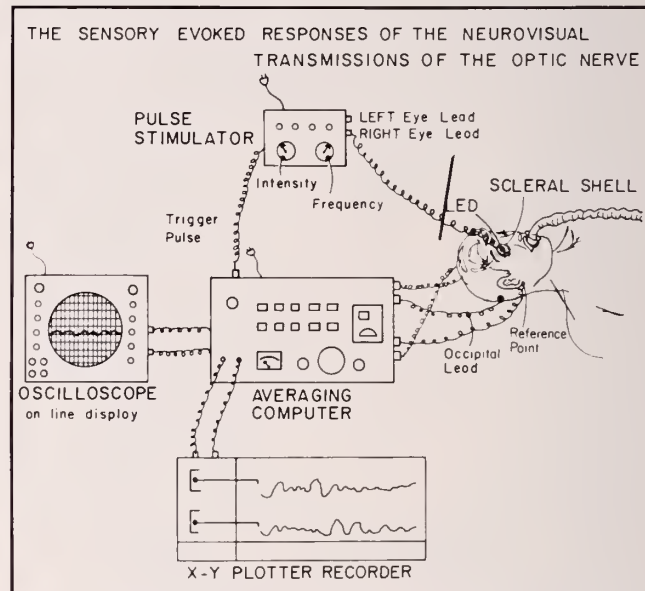


Fig. 4—A schematic diagram for the monitoring of the optic nerve during the operative procedure.



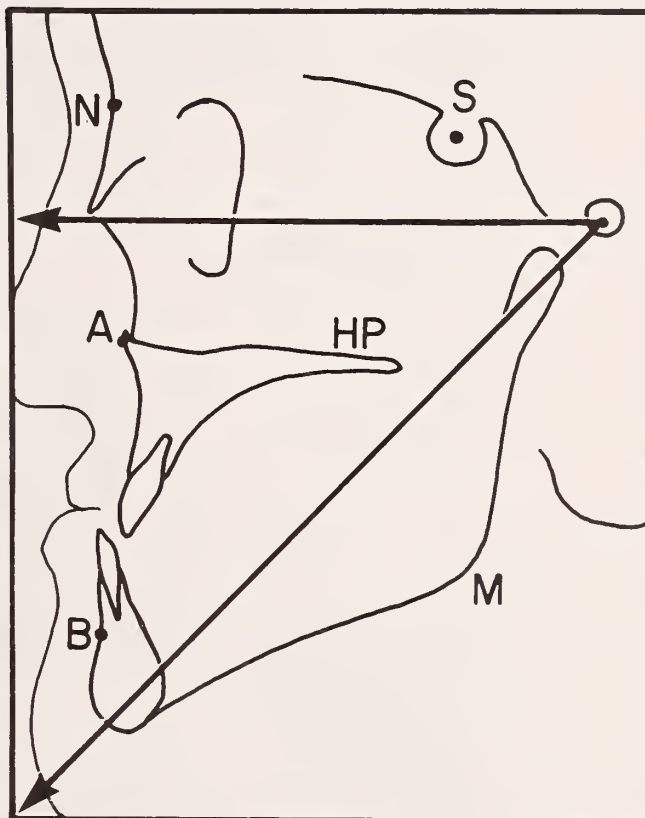
Fig. 5—A photograph of a patient with exorbitism. Note the widening between the orbits and the protrusion of the oculus.



Fig. 6—A. Preoperative photograph of a patient with dish-face deformity. The deformity is related to the lower part of the orbit.



B. Postoperative photograph of the same patient. Note the restoration of the facial balance with mid-face advancement.



C. An outline of the vectors of movement in the facial corrective surgery. A forward and downward movement is achieved.

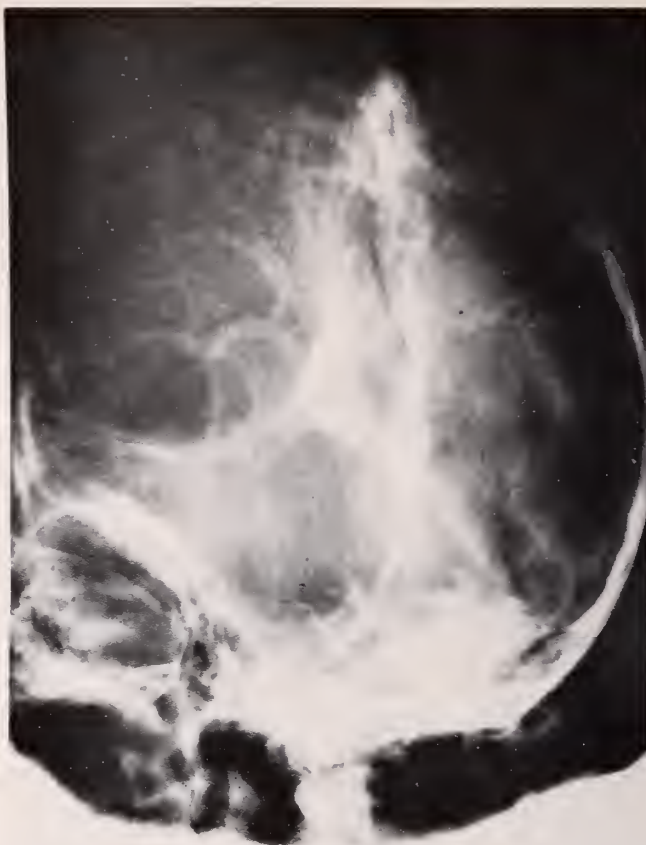


Fig. 7—A. Severe facial deformity in a teenager with absence of the orbit and all the ocular structures on one side.

B. A radiograph of the same patient. Note the main problem extends to the intercranial structures.

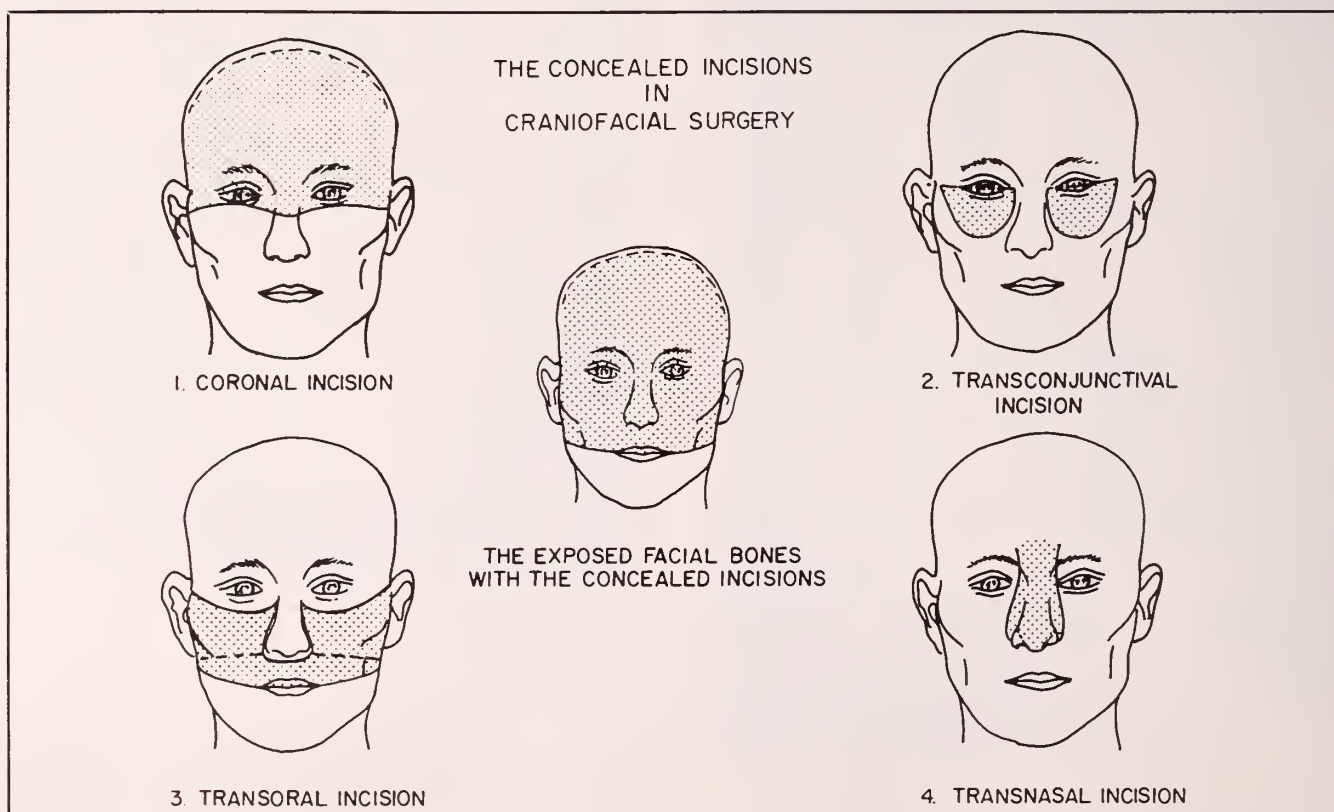
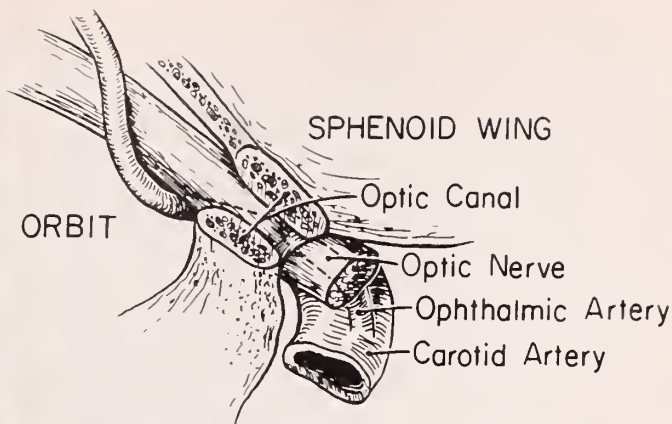


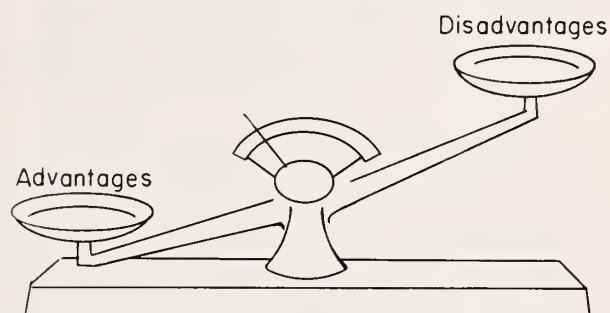
Fig. 8—A diagram of the different concealed incisions used on the face. The purpose is to avoid any apparent scarring.



Fig. 9—A. The optic nerve and its surrounding structures under magnification as viewed from the orbit.



B. The optic nerve and its surrounding anatomical relationship in the optic canal.



Acceptable Surgical Procedures

Fig. 11—An illustration of the major principles used in surgical decisions for habilitation of major facial deformities. Determine that the advantages outweigh the disadvantages to gain an acceptable procedure.

ORBITAL VOLUMETRICS

VOLUME OF ORBIT $1/2 \pi R^2 H$

WIDTH

ADULT: 4.0cm

CHILD: 3.7cm

DEPTH

ADULT: 5.6cm

CHILD: 3.9cm

ORBITAL VOLUME:

CHILD: 23.53cm^3

ADULT: 35.19cm^3

CROUZON'S DISEASE: 13.82cm^3

ADVANCING ORBIT 1.7mm

INCREASE ORBITAL VOLUME: 41.27%

Fig. 10—The orbital volumetric measurements are important in predictions of the results.

Clinical Materials • This report is based upon our experience in the treatment of more than 150 children between the ages of one month and 48 months with major deformities in the cranio-orbital region. They were selected from among more than 500 patients. The main criteria of operability relate to the ability to be rehabilitated to assume adequate function in society without derangement. The patients were evaluated by an interdisciplinary team of professionals with particular expertise in clinical problems related to the cranio-orbital region. The team members help in initial planning and participate in evaluation of results; however, operative procedures are performed by the craniofacial neurosurgeon and the craniofacial plastic surgeon, each with particular expertise in the problems related to his specialty.

Clinical problems encountered in these patients can be divided into the following categories based on the major anatomical abnormalities.

1. Cranial. The clinical problem is found in the upper part of the orbit. It is related to disfigurement of the cranium. Reshaping the cranium and upper orbits is done in a combined cranio-orbital fashion. An example is illustrated in Figure 1. This patient had a large hydrocephalic head which prevented his performing usual daily activities. He was bedridden and unable to move from side to side. A staged procedure assisted in his rehabilitation by reducing the size of the skull 63%.

2. Hypertelorism. The major problem in these patients is a lateral translocation of the orbits and orbital contents. One or both orbits may be involved. The primary aim of the corrective procedure is to move the orbits medially by excising a central core of bone followed by osteotomizing the orbital bones around the oculi (Fig. 2). The free orbits are then fixed in the central median location and bone grafts fill the surgically-created lateral spaces. The patient selected for illustration had the orbits rotated medially 17 mm (Fig. 3).

This deformity should be corrected early in life as an attempt to help these patients achieve neurovisual fusion. The optic nerve function of neurovisual transmission can be easily monitored intraoperatively to prevent inadvertent injury to the nerve. Use of the visually evoked response is a new "on-line" procedure used during the cranio-orbital corrective procedures (Fig. 4).

3. Exorbitism. The orbits in such clinical conditions are shallow; thus, the oculus protrudes due to lack of space in the bony structures of the face (Fig. 5). The end result is severe conjunctivitis and keratitis. The orbital rims are surgically moved forward to create enough new space to house the oculus, then the lids are able to assume their normal physiologic function of protecting the cornea.

4. Dish-face Deformities. In such circumstances, the upper part of the orbits are normal while the lower part is deficient. Treatment involves moving the lower part of the orbit and mid-facial structures. In the majority of these patients the face has to be moved downward and forward (Fig. 6) in order to achieve a normal balance.

5. Unspecified Deformities. A number of patients do not fit into any category of known problems. An example is illustrated in Figure 7. The treatment plan is customized so that there is a new approach for each, based upon the innovative abilities of the treating team.

Comments and Conclusions • These operative procedures are carried out on selected patients, and careful planning decreases the risk of complications. Such planning includes a three-dimensional study of the skeletal structure of the face and a careful look into the cerebral structures by computerized axial tomograms and polytomograms. These procedures are done through concealed incisions (Fig. 8) which provide a direct route for the surgeon to "deglove" the skeletal bones completely so he can perform the precision cuts and alignment. An important factor is avoidance of any major deformity due to an external scar that cannot be corrected later.⁶

Our understanding of the cranio-orbital region was enhanced by knowledge of the fine detailed structures on and around the optic nerve (Fig. 9). The restrictive bony structures surrounding this nerve are an important factor in inhibiting the mobility of the nerve and are the main reasons for impairment in vision that may ensue in certain circumstances.⁷ If such a problem is present, release of the tight periorbitae causes less damage to the nerve. The bone movements cause major changes in the volume within the orbit which produce the major functional and cosmetic results needed (Fig. 10). The face is the image of the person to the outside world and any improvement, no matter how small, enhances the psychosocial status of the patient tremendously.

As with any operative procedure, there are potential major and minor complications depending on the extent of the operative procedure. A seven percent complication rate corresponds with the experience of others in major craniofacial centers. Some of the possible disadvantages can be outweighed by the advantages. This is what makes an operative procedure acceptable to the treating surgical team and to the family or patient (Fig. 11).

The treatment complication which differs from major pediatric surgical procedures is related to cerebral edema. Avoidance of continuous trauma during manipulation of the cerebrum decreases the risk. We have not seen any isolated optic nerve

damage, a result of keeping in mind the major anatomical details of the optic canal.

Prospectus • This new frontier in pediatric neurosurgery and pediatric plastic surgery has opened a horizon for treating patients with various other related congenital problems and acquired deformities. The 1980s will witness an advance in the prominent role of early corrective procedures as a major part of the rehabilitation plan for children with facial problems. The three major areas in this new focus of craniofacial surgery that will be making significant advances are:

1. Craniosynostosis. Patients born with craniosynostosis are having the cranial and orbital regions corrected as early as possible in childhood. Experience with 32 children with more than four years' follow-up has demonstrated to us that postoperatively these children have a normal facial growth and in all probability will grow to be "normal" kids with no problem in development, and no need for further rehabilitation procedures.

2. Cranio-orbital Trauma. A similar approach to the previously discussed problem. The difference is that the severe and extensive fractures are considered uncontrolled osteotomies. The repair indicated is early and immediate with abundant use of bone grafts when indicated. These patients will not have any period of disfigurement and ongoing rehabilitation measures will not be necessary.

3. Cranio-orbital Tumors. Tumors in that region can now be excised and the area reconstructed with bone grafts, primarily so that the children will have no period of disfigurement. The

treating physician should not need to be concerned about any major rehabilitation.

These procedures are not in development but in the stage of wide application. We hope to see more physicians become interested in these major pediatric problems. Early recognition will lead to early treatment and better results. Early rehabilitation can be achieved by an early cranio-orbital procedure. The future will witness a direct involvement in the pediatric procedures by a team interested in major rehabilitation for the patients in the pediatric age group.

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Epithelial heterotopia in the colon of a child: A case presentation and review of the literature

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ABSTRACT: *Although intestinal neoplasia in children is dominated by the juvenile polyp and to a lesser degree the adenomatous polyp, epithelial heterotopia provides a distinct pathological entity with occasionally unique clinical ramifications. Proposed etiologies include both acquired (primarily inflammatory) and congenital mechanisms with intra-mural, intra-diverticular, and polypoid forms of manifestation. This case represents a rare example of epithelial heterotopia, exhibiting both gastric and pancreatic differentiation, presenting as a polyp. (Key words: heterotopia, juvenile polyp, adenomatous polyp).*

The subject of benign intestinal neoplasia is at once intriguing and perplexing, intriguing in its multivariant manifestations and perplexing in its speculative etiologies. The following case report combines two aspects of this topic, the broader aspect of colonic polyps in children and the narrower realm of epithelial heterotopia. Their varying forms, proposed etiologies, and clinical implications are discussed.

Case report • A 7 month old white male was hospitalized for recurrent rectal bleeding. The bleeding had been characterized by occasional large hemorrhages with intermittent production of blood-tinged mucus.

Radiographic examination with barium contrast medium revealed filling of the lumen of the colon at the level of the splenic flexure by a movable, round mass attached to the mucosa by a thin pedicle. This was thought to represent a large polyp. (Figure 1).

The patient was taken to surgery. On exploration of the colon a 3 cm brown, velvety polyp was found in the descending colon. This was attached to a smooth stalk which extended proximally to the posterior wall of the mid transverse colon where it attached. Polyp and stalk were removed. Following surgery, the patient made an uneventful recovery and has had no further rectal bleeding.

The surgical specimen consisted of a polyp with a 3.0 x 2.0 x 1.5 cm. spherical head and a 1.5 x 1.2 x 1.0 cm. stalk. The head was coated by a rim of smooth, soft, tan epithelium surrounding a central core of gray translucent fibromuscular tissue. (Figure 2). The stalk demonstrated a smooth, brown, outer surface and a dense, red-brown fibromuscular core.

Sections from the head of the polyp reveal a superficial layer of colonic mucosal epithelium which, in places, is replaced by a mucosa resembling that of the stomach. Some of the areas show superficial mucus-secreting cells with underlying glands lined by eosinophilic cells resembling parietal cells (Figure 3). Other regions show branching mucus glands reminiscent of the gastric pylorus (Figure 4). There are scattered areas of mucosal ulceration on the head of the polyp. Beneath the mucosa there is a

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Fig. 1—Barium enema demonstrating lucency at splenic flexure corresponding to polypoid mass.

somewhat thickened muscularis mucosae with underlying sub-mucosal vascular dilatation and edema. The outer muscular layers are unremarkable. Portions of the stalk show a muscular stroma containing islands of serous glands resembling pancreas (Figure 5). No islets of Langerhans are identified. The surface of the stalk is covered by a focally ulcerated colonic mucosa.

Discussion • The spectrum of polypoid colonic neoplasia in children is rather well defined and has been classified by Kissane et al.¹³ into two major categories: Juvenile polyps and adenomatous polyps. By far the commonest variety is the juvenile polyp, accounting for over 90 percent of colon-rectal polyps in the pediatric age group.⁵ A review of eighteen cases of our own over the last five years reflects this high percentage in that 17 of these cases are juvenile polyps.

Histologically, juvenile polyps show a smooth epithelial surface, cystically dilated glands and an edematous stroma with inflammatory cells.⁹ Their true etiology, however, remains a mystery, some authors suggesting that they are hamartomas,^{12, 23} while others offer inflammation alone¹¹ or inflammation in association with another pre-existent lesion (e.g. fibroma, lipoma, or lymphoid follicle)^{3, 23} as possible etiologies. They are generally considered not to be pre-malignant.⁹

On the other hand, adenomas, which comprise one to two percent of all polypoid lesions of the colon in children,⁵ are considered by many to be potentially carcinomatous,^{12, 9} Histologically they consist of hyperplastic buds, strands, and tubes of colonic epithelium surrounding a central fibrovascular stalk.¹³ Their etiology and, in particular, their pre-malignant nature remain unclear, although genetic predisposition, increased susceptibility to carcinogens, and the concurrent presence of juvenile polyps appear to be important factors.⁹

Except in instances of juvenile polyposis and familial polyposis simple excision of the polyp usually results in cure.²¹ Recent experience with colonoscopy in children suggests colonoscopic polypectomy as an alternative to trans-abdominal surgery when excision is indicated.⁸

Epithelial heterotopia, particularly polypoid epithelial heterotopia, stands in contrast to the much more common polypoid entities just discussed. Indeed polypoid manifestations of this condition compose an even more distinct minority, the commoner forms of heterotopia occurring as intramural nodules or within diverticula.

The varying forms of heterotopia appear to be related to the capacity for heteroplasia which is characteristic of the embryonic endoderm and its derivatives.²⁶ This capacity is apparently maintained following maturation.¹⁸

In view of this, Taylor has divided heterotopias into two major categories according to etiology: the acquired and the congenital.²⁵ According to this classification, acquired heterotopias include those differentiations induced by chronic inflammatory processes. Examples of this include intestinal metaplasia of the stomach with chronic gastritis and

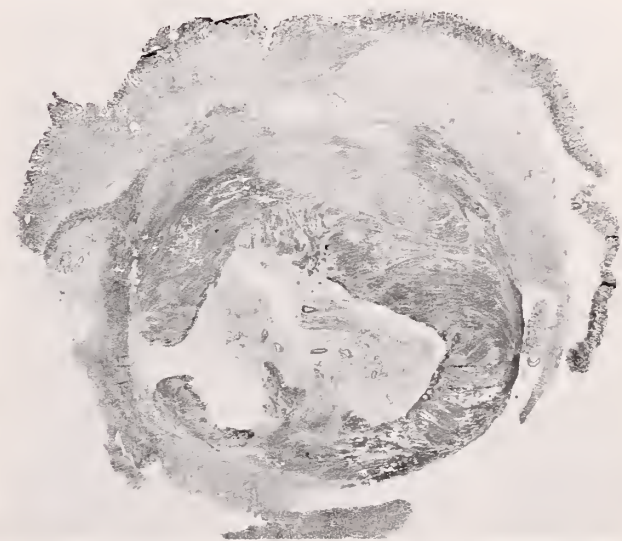


Fig. 2—Cross section of head of polyp showing surface columnar epithelium and central fibromuscular core. H & E, X 4.

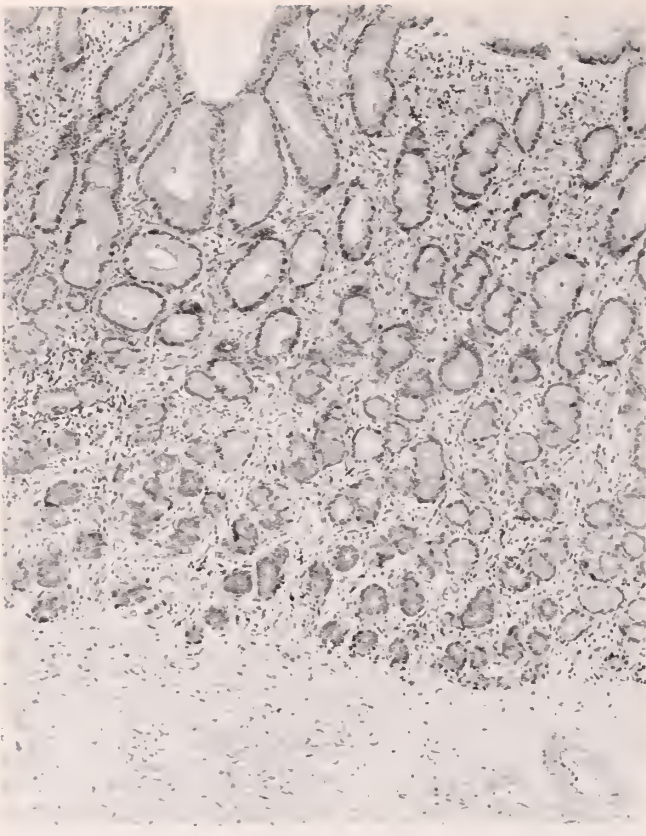


Fig. 3—Segment of mucosa illustrating superficial mucus-producing cells and underlying glands with parietal cells. H & E, X 90.

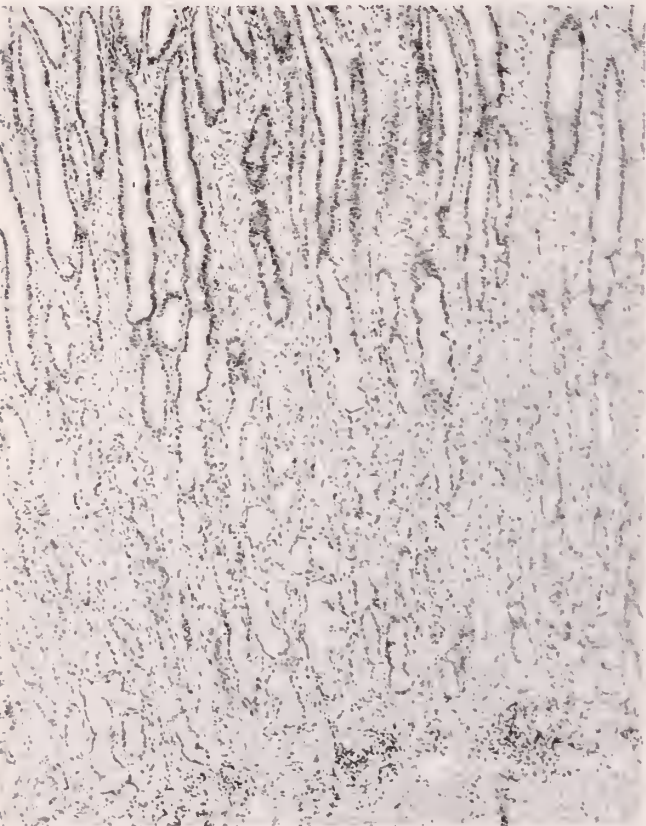


Fig. 4—Segment of mucosa showing branching mucus glands reminiscent of the gastric pylorus. H & E, X 70.

gastric metaplasia of the small intestine in Crohn's disease.² The congenital forms include all those for which no primary stimulus, other than a presumed developmental flaw, can be invoked.

Of particular interest among the congenital forms of heterotopia are those associated with entodermal adhesions during embryogenesis.^{15,1,27,7} The notion that intestinal epithelial heterotopia occasionally results in potentially serious vertebral anomalies can be of great clinical value. Although some of these instances are associated with diverticula, in all likelihood representing attempts at bowel re-duplication,^{15,1,22} others are associated with merely heterotopic mucosal rests.^{1,27}

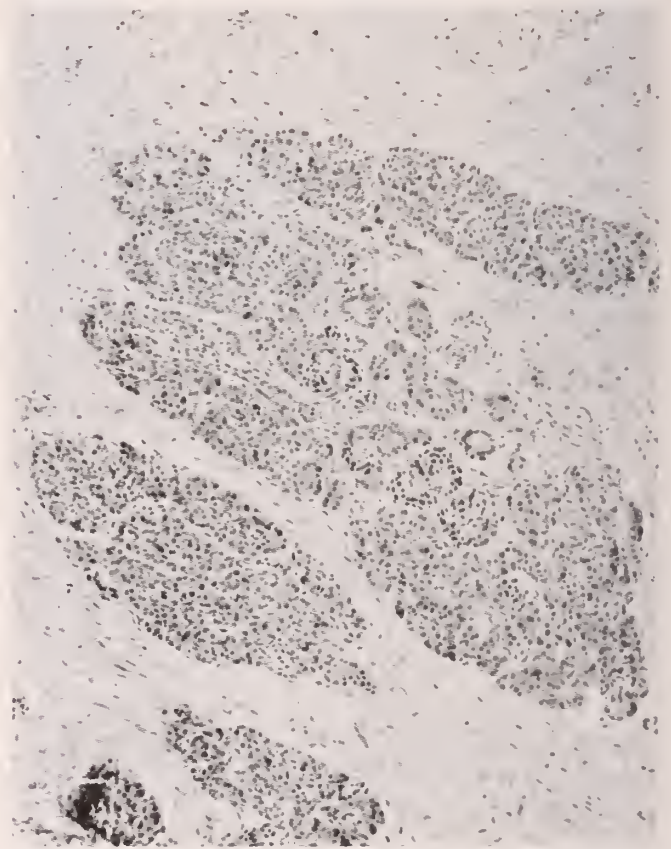


Fig. 5—Cross section of stalk exhibiting pancreatic exocrine parenchyma. H & E, X 90.

Epithelial heterotopia has been documented in virtually all segments of the gut from the esophagus^{17,29} to the anus.²² Even portions of the respiratory tract, which of course buds off the embryonic foregut, have shown such involvement. According to Mitchell & Angrist, the commonest sites of involvement by heterotopic epithelium are the duodenum, the stomach, and the jejunum.¹⁶ The predominant lines of cytologic differentiation among the reported cases appear to be gastric^{27,19,7,22,6,2,17} and pancreatic.^{10,24,28,4} Shindo et al.²⁴ report a rare case containing a focus

of differentiation resembling salivary gland epithelium. The commonest mode of gross presentation appears to be that of intra-mural nodule, although a not uncommon form is that associated with intestinal diverticula (both vitello-intestinal remnants and those resulting from ento-ectodermal adhesions). An extremely rare variant of gross presentation is that of a polypoid mass. Although Picchio²⁰ has described such in the stomach and duodenum, the case just described is another rare example of polypoid epithelial heterotopia.

Conclusion • Colonic neoplasia in children is dominated by the juvenile polyp. Rare manifestations of epithelial heterotopia have been documented in the colon, and other portions of the gut, in children as well as adults. Occasionally these findings have additional clinical value in their prediction of concurrent vertebral anomalies. Although usually manifested as intramural nodules or inclusions within diverticula, this case presentation is an example of epithelial heterotopia presenting itself as a polyp.

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• Dr. Taylor, St. Joseph's Hospital, 3001 West Buffalo Avenue, Tampa 33607.



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FMA Committee on Impaired Physicians

The impaired physician and intervention: a key to recovery

G. Douglas Talbott, M.D.

The Medical Association of Georgia implemented the Disabled Doctors Program in 1975 primarily to insure quality control of medicine and to offer assistance to sick and ill physicians. Subsequently, considerable experience has resulted in identifying, intervening, treating, and helping with the reentry and monitoring of impaired physicians.

Experientially successful, the Program has been asked by other medical societies, associations and groups in the United States and Canada to aid in the impaired physician intervention process. Workshops are being conducted with the primary intent to be useful, helpful, and meaningful in getting impaired physicians well and returned to a successful, sober and happy practice.

Concepts of intervention • Disabled doctors cannot reach out for help and unless the medical community assumes responsibility for intervention eventually their lives will be destroyed. Physicians are not trained, practiced, or philosophically comfortable with intervening, but confrontation is caring.

There are personal, cultural, and professional reasons why impaired physicians cannot ask for help. Paramount—and almost universal—is denial which may be defined as lack of recognition and acknowledgment of the devastation and destruction of the physical, emotional, or social-spiritual-cultural life by alcoholism and drug addiction. The physician's pain on realizing that he cannot stop alcohol or drug use for any sustained length of time is exquisite. Pain repression combined with the altered brain perception from drug use leads to denial.

Additionally, pain repression is aggravated by the realization that the controller has lost control.

In surveying a large number of physicians, loss of control was a primary and extremely distasteful concern. Fueling denial is the cultural attitudes toward disabled doctors. The American culture does not want to see or to recognize the incapacity of heroes; thus, there is a conspiracy of silence among those whose expectations were so great. Additionally, there are reality factors such as fear of legal action, loss of income, professional status and future, destruction of community roles, and loss of family and church which lend to the phenomena of denial and the inability to reach out for help.

Critical to intervention is the fact that some impaired physicians for a variety of reasons cannot, will not, or do not despite repeated and intensive intervention reach out for help.

Historically physicians do not go out and corral patients. For instance, they would not approach the cardiac patient with "you have to come into treatment, we are going to influence your willingness to receive help." However, this is what must happen if impaired physicians are to survive. They must be intervened, coerced, confronted in a loving, caring fashion. Without help their lives spiral downward.

Classification of intervention • The classification of intervention is based upon the constituency of the intervenors. There are basically three types: professional including peers; family, and personal which includes friends and clergy. Frequently interventions are combinations of these types.

Professional Intervention—It is apparent that to the majority of physicians his or her medical diploma represents the ultimate vehicle whereby intervention may occur. The maintenance of disabled doctors' professional lives, in the Georgia experience, is best approached in an advocacy position. Impaired physicians are told the intervenors

The Author

G. DOUGLAS TALBOTT, M.D.

Dr. Talbott is Program Director for Georgia's Disabled Doctors Program, Director of Ridgeview Institute Alcohol and Drug Program, and Associate Professor of Psychiatry at Emory Medical School.

cannot hurt them but can help them by protecting the professional status, the hospital staff privileges, and integrity within the medical society and professional community. Additionally, an advocacy position with the licensing board and Drug Enforcement Agency is also provided. On the other hand the dangers of malpractice, investigation by the DEA and the licensing board as well as revelation of poor medical practice within the local and national media are carefully explained to him or her. This is done by two intervenors who are peers of the impaired physicians. Their training and techniques are subsequently described.

Family Intervention—Family intervention usually involves the nuclear family. In the highly successful intervention program in Georgia, it is customary to have a number of family intervenors present who have been previously rehearsed and trained. When disabled doctors cannot respond to the intervention pleas of their spouses, often they will react to their children, parents, or significant others.

Intervention, while traditionally new and foreign to the medical profession, is caring for impaired physicians who cannot reach out for help.

Personal Intervention—Personal interventions occur when family members are not available or when professional intervention is not feasible or constructive, such as early in the disease when drug effects have not impacted his or her work. Intervenors are close friends, associates which are outside his or her professional life, or clergy of their faith. As mentioned earlier, a confrontation of all three types are more effective than any singular approach.

Training of intervenors • Intervention with the sick as it relates to confronting and bringing patients into treatment is a new experience and concept for physicians involved in the Disabled Doctors Program. Consequently a philosophy that "Confrontation is caring because disabled doctors cannot reach out for help" must be instilled into each physician confronter.

Intervenors should be selected from a group of interested and dedicated physicians in the state medical society. In Georgia, 60 percent must be recovered from the disease of chemical dependency or emotional disorders and 40 percent must be knowledgeable, trained and working in the field.

Intervenors must work in pairs. In Georgia, picked from MAG's Physician Consultant Committee, they work as a team after undergoing training. It is important that their distribution be statewide for confronters must have no professional or social association or relationship with the impaired physicians.

Initially training sessions are held where attitudes are both examined and instilled in each confronter. These attitudes include:

1. Understanding, appreciation and acceptance that alcoholism and drug addiction is a biochemical-genetic disease, not a bad habit, weakness, moral or ethical fault, or psychological disorder.
2. The program presented is an advocacy program; it is not to punish.
3. It is a state medical society program, not a private or local effort.
4. It is a disease involving the family and their loved ones need to be included and helped.
5. Reception to the intervenors may be anger, threats, hostility, or massive denial; they must be prepared for this.

Examination of the current attitudes of the confronters are critical. They must be able to handle hostility, anger, and threats. They must be prepared to listen to statements like, "I am going to sue you; I am going to kill you; I am going to ruin you professionally."

Reflection on the excuses for previously not confronting impaired physicians is useful. These include: (1) It won't do any good. (2) He or she would have gotten angry. (3) I didn't know what to suggest or do. (4) It won't work because of his wife. (5) I was afraid of what he might do to himself. (6) It's really none of my business, and (7) There are legal and financial reasons not to confront.

Techniques of intervention • Two intervenors, now trained, call the impaired physician and ask to see him or her. The Georgia experience has shown that no discussion should be attempted on the phone. The message should be:

1. We represent the State Medical Society.
2. We need to see you immediately on personal professional business.
3. This is too personal to discuss on the phone.
4. We will be happy to see you at the State Medical Society office, your home, or your office.

5. If you desire to check the validity of this call, you may call this person at this number at the State Medical Society.

An immediate date, time, and place is then arranged.

Intervenors carry an identification card on the back of which is printed a checklist. It is their responsibility to implement this list.

1. Clearly define goals and objectives of the visit. Have a specific end result, program, or plan in mind for the sick doctor that will be implemented when the pair of intervenors leave.
2. Anticipate and be prepared to deal with denial, hostility, and the defenses.
3. Have documentation—Demonstrate a paper where his or her behavior, actions, and acts of alcoholism, drug addiction, or emotional disease are documented.
4. Mobilization of the support systems—Have the wife or husband involved in the intervention as well as the children. The partners, peers, nurses, or hospital administrator are excellent support systems. Previous visits by the intervenor team have prepared them. This is called "Intervenor Homework" and may require two or three visits before the impaired physician is confronted.
5. Present specific treatment plans—Give the disabled doctor specific treatment plans and programs. Do not let him choose his "friendly medical school pal" to treat him. Warn him that these treatment alternatives presented to him are the only ones acceptable to the Medical Society.
6. No personal or professional relationship is essential, as the denial syndrome of the impaired physician will seize on such relationships and destroy the effectiveness of the intervention.
7. Provide adequate time as this is the most critical moment in this physician's disease. You are asking, as intervenors, to change this person's life, this impaired physician's professional future. You may have to extend your visit to several hours, you may have to come back a second time. Be prepared to provide adequate time.

Once the intervenors are comfortable with the checklist they are ready to implement the intervention. Having set up the confrontation they arrive at the destination agreed upon by the impaired physician.

Initially identifying themselves as from the State Medical Society, they assure the impaired physician that their role is one of advocacy. They are here to help, not hurt. They are here principally to

protect the professional integrity of the sick doctor as they treat his or her disease. Two techniques are used. First, the recovered impaired physician from the intervening team discusses his disease and recovery, pointing out that this is a treatable situation and the behavior, actions, emotions, and consequences are secondary to the illness. Second, emphasis is placed and elaborated upon that the physician is suffering from a disease, not sick, bad, evil, weak, or crazy.

After these initial explanations and reassurances of the advocacy nature of the visit, the physician is told that he or she may ask the intervenors to leave. However, if they do so, they will return the next day. If this team is unsuccessful, the following week two more intervenors will visit, and after that two more, each spending two sessions so that true platooning is accomplished. Documentation is necessary and should be written but not given to the disabled doctor. In reply to the question, "Who turned me in, I deserve to know," the answer is that this is an advocacy program," Nobody is interested in punishment or punitive action and it doesn't matter who turned you in. You are sick, you need help, and it is clearly established by the current two medical society experts that you need help." As mentioned earlier, because of intervention homework family, peers, administrators, and supervisors, as well as clergy are visually present. Involvement of these support systems, although their presence is time consuming, is often critical to success.

Examination of the current attitudes of the confronters are critical. They must be able to handle hostility, anger, and threats.

Specific treatment plans and programs are presented. Alternate plans countered by the impaired physician must be acceptable to the management team of the intervenor group. It is important to emphasize the need for a committee, team, or council that the intervenors must report to so that decision making and responsibility is not left to them alone. Such a committee must supervise not only the quality and techniques of intervenors, training, and intervention but must be involved with assessing when intervention should be initiated and what to do with disabled doctors who refuse all help. Emphasis is provided the impaired physician and the medical community that this is the State Medical Society's program.

Following a careful intervention with the support systems present, the impaired physician is visually ready for help. He or she is then presented a contract. Item three of the contract is critical. It

DISABLED DOCTORS PROGRAM
MEDICAL ASSOCIATION OF GEORGIA
DISABLED DOCTOR'S CONTACT

NAME: _____ DATE: _____

The Disabled Doctor's Contract is a document which specifies the terms under which the Disabled Doctors Program agrees to assume an advocacy to the DEA, Licensing Board, Hospital Boards, Medical Societies, etc.

Experience in the Disabled Doctors Program has shown this contract to be valid in preventing any misunderstanding of the terms and the time specified. This contract is specially designed to meet the needs of each individual and is uniquely suited to the individual.

1. I, _____, agree to the terms of this contract for a period of one (1) year from the date of this contract.
2. I understand that all expenses connected with my treatment in the Program are to be rendered at my own expense.
3. I agree to cease the practice of medicine until clearance is received from the Disabled Doctors Program.
4. I agree to enter _____ Hospital for evaluation, detoxification, and rehabilitation of 30 days or longer.
5. I agree to Phase II of treatment which will consist of 29 days or longer in an outpatient program at the DeKalb Addiction Clinic.
6. I agree to remain in the Program for Phases III and IV of treatment which consists of 60 days or longer of staff training, gradually phasing into practice during this period of time.
7. I agree to live in a halfway house or accommodations as specified by the Treatment and Management Team during Phases II, III, and IV.
8. I agree to attend the Tuesday evening Caduceus Club meetings. On returning to my home community, I agree to attend Caduceus Club as specified by the Aftercare Committee.

9. I agree to attend the Tuesday evening closed therapy group for doctors held by Mr. Wade Hopkin or Dr. Tom Butcher.
10. I agree to completely abstain from any mood-changing drugs (alcohol, sedatives, stimulants, narcotics, soporifics, over-the-counter drugs, etc.) except on prescription from my family physician after consultation with the Disabled Doctors Program.
11. I agree to obtain urine samples for drug screens at the discretion of the Treatment and Management Team.
12. I agree to identify a primary care physician before completion of Phase I.
13. I understand that no member of the Disabled Doctors Program of the Medical Association of Georgia can appear as a witness in my behalf in the event of legal problems incurred before or during my tenure in the Disabled Doctors Program.
14. I agree to the following special terms as applies to my disease (if any are stipulated).

APPROVED:

Chairman, Treatment and
Management Committee

Program Director, Dis-
abled Doctors Program

Disabled Doctor's
Signature

Witness

Witness

spells out that the impaired physician will not practice again until cleared according to the advocacy position of the State Medical Society as it relates to licensure, medical staff positions, and medical standing in the community. Help with personal, financial, and legal problems are also implied.

Problems and Failures of Intervention • Experience in the Georgia program has proved that within the last 90 interventions there has been a 97 percent success rate in getting impaired physicians into the Disabled Doctors Program. This is compared to the less than 75 percent in the first 90.

However, since failure, utilizing a sophisticated platooning system, still occurs a list of confrontation failure factors has been assembled. These are specified:

1. Insufficient training - This is either in the confronters not understanding alcoholism and drug

addiction as a disease but rather as weakness or moral and ethical issues, or the confronters were frightened, scared, or baffled by the hostility, anger, and denial.

2. Inadequate time allotted - The "homework" was not done so the support systems were not utilized, documentation not provided, or specific treatment plans not presented. Additionally, just not enough time was provided to break through the denial and fear of the disabled doctor, or a second visit could not be scheduled soon enough.
3. Insufficient documentation - Rumors, gossip, and innuendos may not be used. Promising non-disclosure to the disabled doctors, intervenors need to specifically document abnormal circumstances, behavior, scripts, telephone calls.
4. Support systems not utilized - An angry wife, nonsupportive partner, or lawsuit frightened

peer can ruin an intervention. They are usually a product of inadequate homework by the intervenors.

5. Nonspecific treatment plan - It is not adequate to tell impaired physicians they have a problem and let them choose their treatment. Their denial will dictate an inadequate treatment program. The intervenors must present specific solutions and programs to these sick doctors.

Have a specific end result, program, or plan in mind for the sick doctor that will be implemented when the pair of intervenors leave.

Critical to intervention is the fact that some impaired physicians for a variety of reasons cannot, will not, or do not despite repeated and intensive intervention reach out for help. There then must be an ultimate solution. The intervenors report to the Intervention Committee (MAG's Physician Consultant Committee). Ultimately this Committee reports to the Disabled Doctors Committee which in turn is finally responsible to the Council of the Medical Association of Georgia. If repeated intervention fails, the impaired physicians are given time to reflect, as are their families, peers, and hospitals to the dangers of malpractice and publicity in the press. However, after a short reflection time, if it is felt that the sick doctor is a danger to patients, then he or she is told the advocacy position will be abandoned in that the Intervention Committee will file a report with the Disabled Doctors Committee, who in turn will file a report with Council of MAG. Only the Council of MAG can make a decision to notifying the examining and licensure board.

This time-consuming and cumbersome method not only emphasizes the integrity of the advocacy concept of MAG's Disabled Doctors Program but provides quality control of medicine in Georgia by assuring ultimately that sick doctors will not practice if help is refused. Such an ultimate system of licensure revocation after intensive, advocacy intervention has failed is necessary and proper for quality patient care.

Summary • Intervention, while traditionally new and foreign to the medical profession, is caring for impaired physicians who cannot reach out for help. The concepts, dynamics, and techniques of intervention have been presented. In the Medical Association of Georgia's Disabled Doctors Program, these techniques have elevated the success rate of intervention from 75 percent in the first 90 interventions to 97 percent in the last 90 interventions, as measured by voluntary admissions to the Program. The American culture, malpractice suits, and the media find these neglected impaired physicians unacceptable; thus intervention by the medical societies is critical and life saving.

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- Dr. Talbott, 3985 South Cobb Drive, Suite 210, Smyrna, Georgia 30080.

Florida's death registration system

Physicians perform a vital role in Florida's death registration system. Florida law (Section 382.081, Florida Statutes) mandates that "The medical certification of cause of death shall be furnished to the Funeral Director, either in person or via certified mail, by the physician, Medical Examiner or coroner responsible for furnishing such information."

The law further states "the medical certification shall be completed and signed and made available within 48 hours after death by the physician in charge of the patient's care for the illness or condition which resulted in death, or the physician last in attendance upon the deceased, who shall certify over his signature the cause of death to his best knowledge and belief, except when inquiry is required by the medical examiner or coroner." The responsibility to provide certification as to cause of death is understood and accepted by most physicians. However, all do not adhere to this legal responsibility for one reason or another. This, of course, results in a breakdown in the system.

An example of this occurs in cases where the physician is reluctant to sign the medical certification of cause of death when he "has not attended nor seen the deceased for several weeks or months prior to death." A more common occurrence involves cases where the physician is away from his practice and apparently leaves no one available who is able to provide medical certification when one of his patients dies. Another frequent example of the system breakdown is when a "covering" physician is unwilling to provide the medical certification of cause of death.

Such events are occurring among doctors with increasing frequency. It is cause for concern; therefore, physicians are urged to evaluate their role and responsibility to provide cause of death information within the death registration process as mandated by Florida law.

Physicians are urged to evaluate their role and responsibility to provide cause of death information within the death registration process as mandated by Florida law.

The need for promptness by the physician in certifying cause of death cannot be stressed too strongly. Florida law gives the "Funeral Director, Direct Disposer or whoever first assumes custody of the dead body" the responsibility of obtaining the necessary personal data as well as the medical certification, and filing the certificate with the Local Registrar in the County in which death occurred within three (3) days after death - under extenuating circumstances five (5) additional days.

When the legally mandated time frame is overlooked or items are completed incorrectly or left blank, delays in filing the death certificate occur. When the filing of the certificate is delayed, the entire process of settling the estate and securing income for survivors and other necessary uses are likewise delayed. This creates a hardship on those involved. When each fulfills his responsibility in an orderly and timely fashion, problems are minimized.

Prepared by the Florida Department of Health and Rehabilitative Services Office of Vital Statistics.

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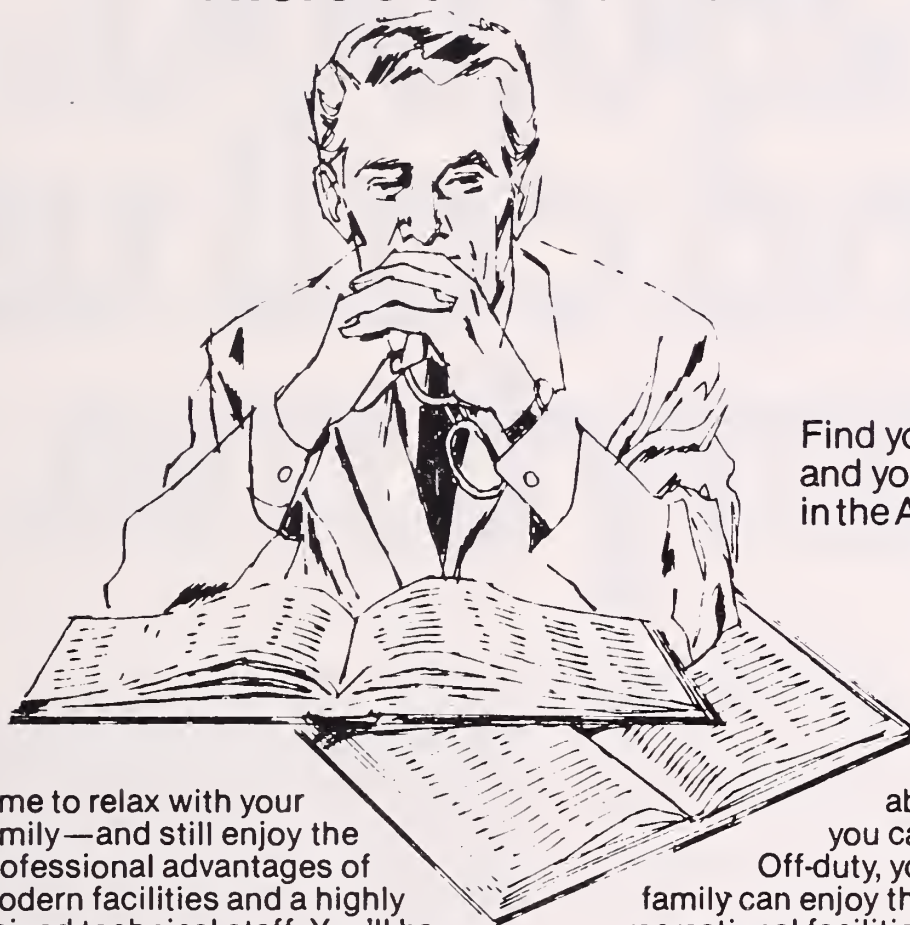


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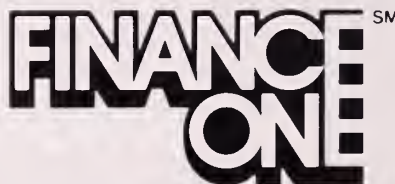
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NOTES & NEWS

Impaired physician workshop scheduled in Tallahassee

The Committee on Impaired Physicians of the Florida Medical Foundation will conduct its third "Workshop on Intervention with Impaired Physicians" in November.

The session will be conducted all day Saturday and Sunday, November 6-7, at the Hilton Hotel in Tallahassee. Course director is Dolores A. Morgan, M.D., of Miami, Medical Director of the Impaired Physicians Program.



Robert E. Windom, M.D., President of the FMA, (right) met with O. Frank Agee, M.D., Professor of Radiology at the University of Florida College of Medicine. Dr. Agee currently is working with a British team of physicians who have developed whole-body Nuclear Magnetic Resonance Tomography at the Hammersmith Hospital and Post Graduate Medical School in London.

Purpose of the workshop is to train physicians to intervene with physicians suffering from alcoholism or drug addiction and to guide them into appropriate treatment and rehabilitative programs, according to Committee Chairman Guy T. Selander, M.D., of Jacksonville. Previous intervention workshops were held during 1981 in Miami and Tampa.

No registration fee will be charged, and a complimentary luncheon will be provided to workshop participants both days. The Committee will apply for approval of the program for AMA Category I CME credit.

Additional information may be obtained by contacting: Mr. Edward D. Hagan, Florida Medical Foundation, P.O. Box 2411, Jacksonville, Fla. 32203, telephone (904) 356-1571.

Dr. Orris Rollie chairs national committee

Orris O. Rollie, M.D., of Orlando, has been appointed Chairman of the 1983 Committee on Scientific Programs for the National Conference of the American Academy of Family Physicians.

Dr. Rollie, Assistant Director of the Family Practice Residency Program at Florida Hospital in Orlando, also is Chairman of the FMA Subcommittee on Annual Meeting Scientific Program.



DEAN'S MESSAGE

UM medical school observes thirtieth anniversary

When the editorial staff of *The Journal of the Florida Medical Association* reestablished the Dean's Page, it was decided that the best way to rotate the three medical school reports would be by drawing names from a hat and then maintaining the sequence. The University of Miami drew the September issue and the coincidence is most propitious because on September 1, 1982, we will enter the 31st class and thereby celebrate the 30th Birthday of the first accredited school of medicine in the State of Florida. Our 25th Anniversary was honored by the FMA in a special issue of *The Journal* which featured the history of the University of Miami School of Medicine. We would like to review that article here, along with a five-year update and a brief view of our aspirations for the future.

Florida did not have an accredited medical school until the University of Miami graduated its first class in June 1956. Late in the 1880's the

Tallahassee College of Medicine and Surgery established an apprentice-type institution. However, no students were ever graduated. Until 1952, residents could obtain professional training only outside Florida. Late in the 1940's, the State Legislature began to consider the establishment of a school of medicine within the State. Senator R. Bunn Gautier, from Dade County, was the prime mover in the passage of a bill which committed the State to subsidize the "first" accredited and approved medical school. The legislation provided that a sum of \$3,000 was to be paid to the school for each Florida resident enrolled. The legislation became law in July 1951, and in September 1952, with four faculty members and 28 students, the School started holding classes in the servants quarters (affectionately known as the Anastasia Building) of the old Biltmore Hotel in Coral Gables, Florida.

The First Curriculum • The first departments created were those essential to providing a freshman curriculum and included anatomy, biochemistry, physiology and psychiatry. In 1953, microbiology, pathology and pharmacology were added. In the ensuing years, we have established 23 departments.

In 1954, the University of Miami and Dade County signed an affiliation agreement which made Jackson Memorial Hospital the primary teaching facility of the new medical school. This affiliation was to lead to the creation of a great medical center which has had tremendous impact on South Florida and surrounding communities.

Despite limited financial resources, the University of Miami School of Medicine has in 30 years achieved a strong position among the nation's medical schools. We have an outstanding faculty which is nationally and internationally recognized. We have established a strong medical education program, become a leader in biomedical research and are responsible for the health care of a sizeable portion of both the public and private patients in Dade County, South Florida, as well as in the Caribbean.

A brief review of the latest institutional profile provided by the Association of American Medical Colleges is further evidence of the prominence of the State's first school of medicine. We are responsible for the supervision and training of one of the nation's largest postgraduate (intern and resident) programs at Jackson Memorial Hospital and the Veterans Administration Medical Center. The regular operating expenditures of the Medical School for 1982-83 will be over 50 percent of the total operating expenses of the entire University and the ninth largest of any school of medicine in the nation. There are presently 713 fulltime faculty who have appointments with the School of Medicine. Many Dade County physicians also serve on the School's clinical faculty and provide an excellent resource for the training of students. In an era of in-

creasing competition for federal support, the School has maintained the rank of 25th among the nation's 126 medical schools in total sponsored research and training. It is 13th in the recovery of federal indirect costs. Total expenditures were the 12th largest of any biomedical institution in the nation.

Fully Accredited • The most recent visit from the accreditation team of the Liaison Committee on Medical Education resulted in a full accreditation for seven years; the maximum time allowable. The accreditation team, composed of national leaders from the American Medical Association and the Association of American Medical Colleges, praised the School for the development of a modern medical campus, its recruitment and retention of outstanding nationally recognized faculty, the excellence of the student body, maintenance of significant extramural financial support from all sources, a fine administrative relationship with its primary teaching hospital, our commitment to a single standard of medical care for all patients served, as well as the innovative Ph.D.—M.D. program initiated at this institution. Virtually every concern of the team was remedied within six months of the report. The only one that still requires resolution and will require continued work relates to our vast and nearly overwhelming commitment to patient services. The team's primary concern was not related to our private practice but to the extraordinary volume of public patients that require clinical care at the Jackson Memorial Hospital. They felt that the volume of patient services required could eventually have an adverse effect on teaching and research. It is interesting to note that that issue was discussed even prior to the most recent influx of Cuban and Haitian refugees.

The University of Miami School of Medicine, as well as all academic medical centers in the nation, is facing complex challenges. Support for medical education has decreased significantly, the availability of research funds has declined, and the federal support for patient services drastically changed. However, coping with obstacles indigenous to growth has taught us how to meet such challenges. Doing so has been made easier because of the tremendous support of the State, the citizens of Dade County, the creation of the Public Health Trust which governs the Jackson Memorial Hospital, as well as total dedication of our faculty, students and alumni.

Everyone who shared in the creation of what in my biased opinion is a truly fine medical school, should be proud of what has been accomplished.

*Bernard J. Fogel, M.D.
Interim Dean
School of Medicine
University of Miami
Miami*



What do you tell a dieter

The old American tradition of the traveling medicine show lives on—only now instead of Old Doctor Greybeard's Snake Oil Elixir being sold from the back of a traveling wagon, we have the itinerant doctor selling magical diets from a chain of fixed clinics scattered over the countryside. The set-up is perfect. Obesity is widespread (up to 35% of adult Americans are overweight), healthiness (as defined by the "beautiful body") is in vogue, and there is no satisfactory legitimate medical treatment available.

Those of us who try to be honest with our patients only add to the problem. We can tell them that severe obesity is dangerous. There is a significant increase in morbidity and mortality from cardiovascular disease, hypertension, diabetes, osteoarthritis, etc., among the grossly obese. The psychological effects of obesity can be extreme. We must also admit, however, that there is no easy way out. The choices available at this time are between surgery and calorie restricted diets. The multitude of surgical procedures tried so far have resulted in varying degrees of success, but at a cost of dangerous complications in many cases. These procedures must still be looked upon as experimental and certainly are out of the question for the usual mildly to moderately overweight patient.

So what can be done to make dieting easy? There was a time that amphetamines were popular—despite the fact that they rarely depressed the appetite for more than a few weeks and sometimes produced such annoying side effects as psychotic behavior. Fortunately, our state has finally taken a stand in declaring such therapy as unethical. So now we have a series of amphetamine analogs that have reduced dangers, but in the process have also been rendered even less effective than the parent compounds.

To fill this void of safe, effective medicines, the traveling weight doctors have come to the rescue with supposedly safe non-medicines (or medicines in non-therapeutic doses). A long-time leader in this field is the ever popular series of daily injections with Human Chorionic Gonadotrophins. The hundreds of doses of "HCG" that have been given in Marion County without so much as a pelvic exam have not apparently caused a single case of multiple pregnancy or ruptured ovarian cyst. Either we have been amazingly lucky, or there must not be much HCG in those shots. Regardless of the potential dangers, however, the manufacturers of HCG have included in their inserts the bold faced statement

that: "HCG HAS NO KNOWN EFFECT ON FAT MOBILIZATION, APPETITE OR SENSE OF HUNGER, OR BODY FAT DISTRIBUTION." They go on to reiterate in some detail that it is not indicated for weight loss simply because it does not work. The patients, of course, are convinced that the shots *do* work—they cannot imagine that the 500kcal. diet they are also following could be the explanation for their weight loss.

Of course, not all patients are impressed by the magic of daily injections. To attract these people, the diet therapists have substituted all sorts of combinations of vitamins, seaweeds, amino acids, etc. as the special ingredient that makes their own particular diet the one to follow. Basically, these diets all have in common a severe calorie restriction. Most supply around 400 to 500kcal per day. At these levels it is certainly important that vitamin supplementation is adequate to prevent deficiency diseases. At these levels it is probably also necessary that protein make up a major part of the intake in order to suppress hunger. Unfortunately, such diets have a number of drawbacks:

1. Average weight loss on a 300 to 500 kcal diet for an obese patient is about 3.5 lb per week. If obesity is severe, it may take many months to approach ideal weight.
2. Few people can subject themselves to such an extreme restriction for very long.
3. Those who lose weight while on such a diet experience return of most of the weight within a few months of stopping the diet in most cases.
4. Some patients on such diets have suddenly died—even when under close supervision of nutritional experts and regardless of the apparent quality of protein supplements, etc. provided. As body fat is lost, there is apparently a loss of lean tissue as well. At autopsy, myocardial atrophy has often been found.

So what are we to tell our patients? I think we have to tell them the truth. There is no known appetite suppressant that is free of serious potential side effects and effective for more than a very brief initial course. Weight that is lost on near-starvation diets is easily regained—the stomach does not shrink and there is no long term benefit to getting a "good start" on weight loss. Severe calorie restriction is potentially dangerous and no one knows what, if anything, might be done to avoid the danger. In short, weight loss is a hard process, and there should be serious thought put into any decision to spend large sums of money on a short term scheme that purports to make it easy.

Henry L. Harrell Jr., M.D.
Ocala

Reprinted from the *Bulletin* of the Marion County Medical Society, November 1981.

The other side of the desk

An experience with chronic illness

Editor's Note: Dr. Stewart is a retired internist from New York and is now working for the Public Health Department.

This is not an in-depth study of the psychodynamics of chronic illness, and the intricacies of the doctor—doctor as patient relationship. Having just read the last edition of the Medical Staff By-Laws, this is definitely not an attempt to invade the turf of my psychiatric colleagues. These observations stem from my experience with a chronic illness, and from a recent hospitalization during which time I underwent major surgery for the first time (a hip replacement). Being on the other side of the desk is an enlightening experience.

As background, I have had osteoarthritis of the left hip for the past twenty years. Early on, it did not interfere significantly with my professional and social life. But in the preceding ten years, the course of the disease changed significantly, requiring many adjustments in my life style. What's in a name? The bland cognomen Degenerative Joint Disease is not half as appropriate as the older pathologic classification *Malum Coxae Senilis*. The spectrum of adjustment to chronic illness, with its concomitant disability, is a wide one, with these adjustments running the gamut from complete denial, to passive invalidism, depending upon the ego strengths and weaknesses of the patient involved. I must admit that, in my own case, denial was an important coping mechanism. During this period, I was seen by several orthopedists and physiatrists depending on what Medical Center I was associated with. The consensus was that the optimum time for surgery was still in the future; an opinion, which I obviously appreciated. The disease process progressed inexorably, with increasing functional loss and pain. Regarding the former, it's amazing the compensatory physical maneuvers one can learn, to overcome the losses, and maintain an adequate level of performance in the activities of daily living. The problem of pain will be discussed later. As part of the coping process, a sense of humor, and the ability to laugh at oneself, is really important. A couple of incidents come to mind. Hobbling across from one building to another, to get to medical rounds, a reassuring comment from a clinic nurse, "Doctor, you're doing better on your sea legs today." Painfully struggling up a flight of stairs to get to the cafeteria after a particularly busy morning in the clinics, someone took me by the arm, saying, "Doctor, let me give you a hand." Looking around to say

thanks, it turned out to be the last patient whom I'd just seen in the clinic. What a good laugh we both had.

Over the later years, I was managed by the same orthopedist and physiatrist, both of whom recommended the obvious—a cane; a suggestion, which for devious reasons, I was not yet ready to accept. Since we all worked within the same hospital environment, escaping their frequent observation was impossible, and I became adept at making excuses, "I forgot it in the car." "I left it at home." These were no longer valid when I was given a cane by both my orthopedist and my physiatrist. Even the ancillary staff got in the act, and many a day I got a good natured reprimand from a nurse, an aide, or a clerk. This problem was finally solved by carrying a collapsible cane to be whipped out at appropriate times.

The day finally came when the definitive opinion was given. "This is the appropriate time to have the surgery done." There was no comfort from the second opinion: complete concurrence. But the denial mechanism was still operative. Finally, the most important factor in accepting the decision was the pain; functional loss could be adjusted to, and accepted with good humor, but the pain element had a constant substrate, with acute exacerbations, increasing in frequency. For the arthritic patient, I would say that the quality of life is most altered by pain, and that it is the most important factor in making the ultimate decision.

Having made the decision to have the operation, there was a temporary relief of tension, but Nature abhors a vacuum, even a psychological one. The anxieties must now be directed to new problem areas. Such questions had to be answered—where shall we have the procedure done? and by whom? The procedure itself—will there be any complications, minor or major—early or late? What will the outcome be like? How much functional return could one reasonably expect?

What is that classic piece of comforting understatement, "This, too, shall pass." The conflicts were solved, decisions made, and we got admitted to the hospital. The hospital—a place where one surrenders his identity, loses his privacy, and becomes a passive and, at times, unwilling subject, being ping-ponged between the various members of the hospital team; physicians, nurses, x-ray and lab technicians, therapists (physio, respiratory), dieticians and aides, environmental specialists and aides, Pink Ladies, TV rental specialists, etc., etc., (apologies if I left out any members of the team).

The surgery was completed without major problems, and recovery was uneventful, except for a single complication which I shall mention later. With progressive recovery, it was interesting to become aware of a dual role. As a patient, I found

myself comparing notes with patients who had had the same procedure earlier, and sometimes getting overly enthusiastic peer support. In other situations, we found ourselves being sought out by other patients for medical advice and psychologic support. Overall, the entire experience was enlightening, enjoyable and strengthening.

In conclusion, it is useful to remember that the physician-patient is like any other patient with his own singular combination of fears and anxieties, but in addition, because he is a physician, there are many unique factors in the equation. An important one is his own medical knowledge, which may make him more susceptible to worry and more in need of reassurance than his nonmedical counterpart. An amusing incident illustrates this point. Four days post-op, I developed a massive swelling of the entire left leg for which I was given some vague explanations. The next day, when I began having repeated hemotocrit and hemoglobin determinations, I became more concerned and more aggressive in my questioning. When I was finally told that I had developed a hematoma and that the bleeding had stabilized, I could sleep peacefully once again without benefit of Tylenol #3. The next morning, I discussed the problem with the resident staff while they did the daily dressings. As they were leaving the room, I heard one resident say to another, "These internists are always asking all sorts of questions." We got them back to the bedside to inform them that my questioning of the day before was not an intellectual exercise, but an attempt by a concerned patient to allay his anxieties.

In closing, now that I have had the experience of being hospitalized for a serious surgical procedure, I find it particularly appropriate to recall a quotation, first read when I was a medical student, from Ambrose Pare, a seventeenth century French surgeon, "My duty as a physician is to cure sometimes; to relieve sometimes; to comfort always."

*Phillip Stewart, M.D.
Daytona Beach*

Reprinted from the *Stethoscope*, December 1981.

Are we really in business?

As physicians we find we are on many mailing and contact lists. Frequently we are told by mail and in visits to our offices of our need for an accountant, a tax shelter expert, investment counselors, estate planning consultants, stock brokers, real estate investment advisors, a bank advisory service, and a

trust and will expert, to say nothing of an attorney. We are told that we need sophisticated equipment for computer billing, for practice analysis, and financial planning. We are reminded of the need for our office to have supervisors, personnel managers; we must send people to various seminars conducted in multiple locations, having to do with the financial side of the practice of medicine.

Regularly we receive *Medical Economics* and other periodicals filled with suggestions for the "business side of medicine." Where are the articles that speak of ways to increase our service to our patients? Are we really as occupied with the pursuit of the materialistic things of life as some of the literature suggests which is directed to our offices?

A few years ago physicians were viewed with disapproval by their associates in organized medicine if the physician owned a drugstore; today physicians think nothing of owning the hospitals they practice in; and then at a later date when these same hospitals have become profitable (because of the use by the physician), the hospital is then sold at tremendous profit by the individual physician holding shares in the hospital to "national health providers." Physicians today apply for "certificates of need" to start nursing homes, convalescent shelters, and other businesses to increase the financial return to the physician. Physicians set up their own franchised walk-in twenty-four hour emergency room shelters usually located near a hospital with a busy emergency room. All of these enterprises being, of course, directed towards "making a profit."

Has prosperity dimmed the image of medicine? How many patients do you see each week and make no charges for services rendered in your office to that patient? How much time each week do you spend in your office helping a family or a relative understand the illness which a member of the family was undergoing, at no charge? How often are your fees adjusted to allow for the financial hardships and income of a patient at the particular time?


Certainly all of us must make a profit to stay in medicine, but are we making too much? Why does routine laboratory work at various hospitals and laboratories in this area vary so widely in cost to the patient? Are all of our tests, procedures, X-rays, etc. really necessary? If the reason given is that in the present era we must practice "defensive medicine," then the question naturally arises, when does such a practice become "profitable medicine" rather than "defensive medicine"?

These questions deserve our thoughtful consideration. Certainly these problems face us. Our expenses constantly increase, and thus our fees to patients must do so likewise. Are we giving more and more of ourselves to the practice of medicine to justify medicine's increased cost to the patient?

Patients who believe physicians care about them are never involved in critical appraisal of that physician's service. Each of us can determine in our own practice whether we are "service oriented" or "business oriented".

*James J. Crumbley Jr., M.D.
Tampa*

Reprinted from the Hillsborough County Medical Society
Bulletin, January 1982.



CORRESPONDENCE

Family practice medical records An overseas viewpoint

To the Editor: I am a partner in the above family practice, and I am a trainer for young medical graduates who intend to specialize in General Practice. In the U.K. such doctors are known as Vocational Trainee Assistants, (which corresponds with your Family Practice Training Program). During a recent visit to Florida, I was able to make a trip to a few individual Family Practitioners as well as to the Florida Hospital in Orlando; I found the exchange of views fascinating and I learned much from my all-too-brief stay in the State.

When "digesting" all the information and data I had obtained from Medical colleagues in Florida, after my return to Scotland, it occurred to me that the Family Practice medical records I had inspected during my trip, seemed very hospital-oriented in design from the viewpoint of a British G.P. (Family Practitioner). Also, some of the Family Practitioners had expressed interest in the attached Data Base Sheet and Family Planning Sheet, and which I have described in the British medical process.

Accordingly, I have enclosed copies of my articles on: (1) Data Base Sheet and (2) Family Planning Sheet for your consideration or publication in your Journal if you feel they would be of interest to your readers (especially the Family Practitioners, of course).

*Robert Fairley
Stirlingshire
Scotland
United Kingdom*

Editor's Note: Dr. Robert Fairley of Scotland recently was in this country and made some interesting

observations on the differences in family practice medical records in the United States as compared to the approach used in Scotland. His letter details those differences and he offers samples of his forms. Copies of Dr. Fairley's materials are available to our readers upon request.



75,000 Florida residents recruited for cancer study

More than one million Americans including about 75,000 Florida residents, are being enlisted to participate in an American Cancer Society study to be carried out over the next six years. The project, called the Cancer Prevention Study II, is one of the largest research projects of its kind ever conducted in this country.

The investigation will help determine how lifestyle and environmental factors influence cancer and other diseases.

Participants, who are being recruited by Cancer Society volunteers will fill out a confidential questionnaire about their working, living and eating habits. Questions will concern usage of such products as cigarettes, birth control pills, coffee, hair dyes and saccharin.

Every other year, research volunteers will keep track of the participants, their status and whereabouts.

Mount Sinai is studying pulmonary hypertension

Florida physicians are invited to assist in establishing a registry of primary pulmonary hypertension patients.

Mount Sinai Medical Center of Greater Miami and 34 other centers nationally are working with the National Heart, Lung and Blood Institute on the project. Patients eligible for entry into the registry are those with primary pulmonary hypertension of unknown origin.

Participating centers hope to enroll at least 150 patients during each of the three years of the study.

Florida physicians who have such a patient in their practice are asked to contact: Tahir Ahmed, M.D., Principal Investigator, Division of Pulmonary Disease, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, Fla. 33140, telephone (305) 674-2610.

Medical staff chiefs invited to Alabama conference

A program entitled "Competitors or Partners: The Changing Physician-Hospital relationship" will be conducted in Birmingham, Ala., on September 18 under the sponsorship of the Medical Association of the State of Alabama. Chiefs of the medical staffs of hospitals in Alabama, Florida, Georgia, Mississippi and Tennessee have been specifically invited.

Registration is \$35.00 including a luncheon. Information about the program may be obtained by contacting Mr. Arnold G. Mooney II, Director of Special Projects, The Medical Association of the State of Alabama, P.O. Box 1900-C, Montgomery, Ala. 36197, telephone (205) 263-6411.



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Married to Medicine: An Intimate Portrait of Doctors' Wives

By Carla Fine, 243 Pages. Price \$12.95. Atheneum, New York, 1981.

Carla Fine, a doctors' wife for over 16 years, has attended numerous medical meetings. At these meetings she has seen wives grouped together exchanging small talk, while the doctors discussed medicine across the room. She found herself wondering "who these fashionably dressed, sociable, and intelligent women really were. When they made jokes about having a 'phantom husband,' were they really bitter? When they commented that the nurses that year seemed younger and prettier, were they really threatened? Did their high standards of living compensate for their husband's frequent absences? Were they aware that other women envied them? Did they consider themselves privileged, part of an elite group?"

In her book, *Married to Medicine*, Mrs. Fine has attempted to answer some of these questions. She has interviewed more than a hundred physicians' wives representing a cross section of women married to small town general practitioners, big city specialists, medical students and residents, and semi-retired physicians. The results of these interviews have given her the material to describe the problems of the medical student in "The Struggle"; those of the resident in "Transition"; and those of the public image, sex life, stress and family life of the "Established Success." She does not neglect the problems of doctors married to doctors or the non-physician doctor's husband.

She has found from her interviews that the majority of wives like being married to doctors despite the problems of unpredictable hours, disrupted family life, and playing "second fiddle" to medicine, but they are violently opposed to their daughters marrying physicians.

While Mrs. Fine brings out the many advantages to the spouse in a medical marriage, her primary concern is with the problems encountered in these marriages.

Whatever the stage of our own medical marriage, whether we are spouse or doctor, there is much that is pertinent for us in this book. Some of the problems Mrs. Fine describes we may have already experienced and solved; others we may have with us now; more than likely the future will hold even different ones. Being forewarned may give us a better opportunity of solving them. Even if the examples in these interviews do not fit us personally, knowledge of their existence should give us understanding as our friends and colleagues face them. Even though we have a happy medical marriage, this book will give us a keener insight and an appreciation of our spouses and the life we share in our marriage to medicine.

Ruth Coleman

- Ruth Coleman lives in Tampa, is a past president of the FMA Auxiliary, and has been married to medicine for over forty years.

Book notices

On September 30, 1982, a four-volume set of *Health Science Books 1876-1982* will be published by the R. R. Bowker Company. This will allow for the first time the retrieval of any of the U. S. Medical literature printed in book form since 1876. This will provide a valuable reference source for librarians verifying citations for acquisitions and interlibrary loans as well as for bibliographers and scholars. Prepublication price is \$175.00. Price thereafter is \$200.00 plus shipping and handling.

Current Pediatric Diagnosis and Treatment, Edition Seven, published by Lange, is an excellent, useful comprehensive reference that is very appropriate for everyday use in the Practitioner's Office and should be close at hand.

Be an angel

The Florida Medical Association and the Florida Medical Association Auxiliary are organizations dedicated to the principle that they have an important role to play as citizens in a self-governing society. The Auxiliary is an instrument of public service to the community. Its primary goal is to assist the FMA in its programs for the advancement of medicine and public health for the betterment of the health needs of Florida.

The Auxiliary is a volunteer force of almost 6000 spouses, most of whom are members of the 81,000 member AMA Auxiliary. Membership is exclusive, only doctors' spouses can belong, but all physicians' spouses are eligible (so long as the physician is a member of the FMA).

We volunteer because we believe in what we're doing. We are as diverse a group as you could find anywhere. The Auxiliary is a dynamic group of people working together. It is voluntarism at its best.

Participation is a key word in thinking about membership. In order to have a strong auxiliary we must have widespread participation. We need the doers as well as the passive listeners.

Every effort will be made around our great state this year to make each member feel that he or she is important and needed in our auxiliary. What are some of the benefits of membership?

1. It gives the Auxiliary member an opportunity to share his/her special concerns with others.
2. It offers personal development through free leadership training and educational seminars.
3. It affords information to impact legislation affecting health care and medical practice.
4. It gives the spouse an opportunity for involvement in the community and with neighbors.

For over 55 years, from Pensacola to Jacksonville and from Tallahassee to Key West . . . all over the state of Florida, Auxiliary members have been making the difference in the quality of life and health care in their communities. Their individual talents, training and expertise have been instrumental in originating programs in health careers, child

abuse prevention, safety, international health, science fairs, impaired physicians activities, blood donor recruitment, scholarships and many others. All are ongoing projects developed at the county level.

The FMAA needs your help as a physician in Florida and member of the FMA. Our state is currently ranked third in the nation in membership. We are only approximately 600 members away from being ranked number one. The current Auxiliary membership of almost 6000 is less than half of the current FMA membership. With your help we can easily attain our goal of becoming the largest auxiliary in the nation.

The counties of Florida have been challenged to recruit at least 2500 members this year in our "Each One—Reach One" campaign. Our organization needs this strength to accomplish our goals and to be of the utmost asset to the FMA.

During October, which is our membership month, please "Be an angel". Encourage your spouse to join the Auxiliary or better yet, join for him or her. Simply fill out and mail the form below and an auxiliary will be in contact with your spouse within the next few weeks.

*Jo Tignor (Mrs. Milton)
First Vice President FMAA
North Palm Beach*

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Meetings

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OCTOBER

16th Family Practice Review, Oct. 4-8, Hotel Royal Plaza, Lake Buena Vista. For information: Lamar Crevasse, M.D., Box J-233, JHMHC, Gainesville 32610.

Christian Challenges in the LPS Medicine, Oct. 6-10, Host International Hotel, Tampa. For info: Robert Standish Reed, M.D., 4821 Memorial Highway, Tampa 33614, (813) 884-7559.

Management of Burn Victims: Emergency, Acute and Rehabilitative Phases, Oct. 7-8, Miami. For information: Ms. Gloria Allington, (305) 547-6716.

8th Annual OB/GYN Review Course, Oct. 8-16, Royal Biscayne Hotel, Key Biscayne. For information: University of Miami School of Medicine (305) 547-6944.

First Annual Wuesthoff Memorial Lecture Series: Recent Advances in Medicine and Surgery, Oct. 9, Wuesthoff Memorial Hospital, Rockledge. For information: George Leal, M.D., 1395 N. Courtenay Parkway, Merritt Island 32952. (305) 452-2563.

OB/GYN Pathology Review Course, Oct. 10-12, University of Miami School of Medicine, Dept. of OB/GYN, P.O. Box 016960, Miami 33101, (305) 547-6944.

RX for a Healthy Heart, Oct. 10-15, Sheraton Sand Key Hotel, Clearwater. For information: Henry J.L. Marriott, M.D. (813) 894-0790.

Pediatric Nephrology, Oct. 11, International Hospital, Miami. For information: Eugene L. Nagel, M.D., P.O. Box 927, Lakeland 33802, (813) 682-0543.

Neurology for the Primary Care Physician, Oct. 12, 16, 19, North Shore Medical, Miami. For information: Gloria Allington, University of Miami School of Medicine, P.O. Box 016960, Miami 33101, (305) 547-6716.

Violent Crime: An Epidemic, October 13, Quality Inn, Cypress Gardens, Winter Haven. For information: Eugene L. Nagel, M.D., P.O. Box 927, Lakeland.

Principals of Practice Management, Oct. 13-17, Hot Springs, Virginia. For information: Univ. of Miami, Dept. of Anesthesiology, School of Med., P.O. Box 016960, Miami 33101. (305) 547-6411.

Cardiology for the Primary Care Physician, Oct. 13, 20, 27, South Miami Hospital, Miami. For info: Gloria Allington, Univ. of Miami School of Medicine, P.O. Box 016960, Miami 33101, (305) 547-6716.

Brief and Emergency Psychotherapy: A Seminar, Oct. 14-15, Sarasota Hyatt House, Sarasota. For info.: Nancy Skotchdopole, ACSW, P.O. Box 2024, Leesburg, 32748, (904) 787-9178.

Regional CME Meeting — 14th Annual Joint Meeting American College of Physicians and Florida Society of Internal Medicine, Oct. 15-17, Hyatt Regency, Tampa. For information: Roy H. Behnke, M.D. Univ. of S. Fla. College of Medicine, 12901 N. 30th St., Tampa 33612. (813) 974-2271.

89th Annual Meeting of the Association of Military Surgeons of the U.S., Oct. 17-21, Convention Center, Sheraton Twin Towers Hotel, Orlando. For information: Captain Jay R. Shapiro, USPHS (305) 496-3515.

An Update and Review in Emergency Medicine, Oct. 18-22, Sonesta Beach Hotel, Key Biscayne. For info.: Sharon G. Llera, 8200 West Sunrise Blvd. Bldg. C. Plantation, 33332. (305) 472-6922.

Annual Panamerican Seminar, Oct. 18-22, Mt. Sinai Hospital, Miami. For info: Dept. of CME, Mt. Sinai Medical Cen-

ter, 4300 Alton Road, Miami Beach 33140. (305) 674-2311. (Totally in Spanish)

Annual Medical Aspects of Aging, Oct. 22-23, Gainesville Hilton, Gainesville. For information: Ms. Grace Wagner, Coordinator, University of Florida CME, Box J-233, JHM Health Center, Gainesville 32610, (904) 392-3143 or 3183.

Annual Meeting, American Pain Society, Oct. 29-31, Konover Hotel, Miami Beach. For information: Kenneth L. Case, M.D., Neurology Service, VA Medical Center, Ann Arbor, Michigan 48105. (313) 769-7100 Ext. 296.

New Horizons - Medical Alumni Seminar, Oct. 29, Gainesville, University of Florida Medical Science Bldg. For info: Grace Wagner, CME, JHMHC, Box J-233, Gainesville 32610, (904) 392-3143.

23rd Annual Workshop in Electrocardiology, Oct. 28-Nov. 1, Sheraton Sand Key Hotel, Clearwater Beach. For information: Henry J.L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705, (813) 894-0790.

Annual Meeting, American Pain Society, Oct. 29-31, Konover Hotel, Miami Beach. For information: Kenneth L. Casey, Neurology Service, VA Medical Center, Ann Arbor, Michigan 48105, (313) 769-7100, ext. 296.

Current Advances in Perinatology, Oct. 31-Nov. 6, St. Thomas, U.S. Virgin Islands. For information: University of Miami School of Medicine, Dept. of Pediatrics, P.O. Box 016960, Miami 33101, (305) 547-6411.

NOVEMBER

Pacemaker Electrocardiography and Dual Chamber Pulse Generators, Nov. 3-5, Wolfson Auditorium, Mount Sinai Medical Center of Greater Miami, Miami Beach, For information: Philips Samet, M.D., (305) 674-2311.

Psychopharmacology for the Practicing Internist, Family Practitioner & Psychiatrist, Nov. 4, 5, 6, Dutch Resort Hotel, Orlando. For information: Robert Needleman, M.D. (305) 841-5144.

Clinical Management of Coronary Disease and Dual-Mode Exercise Testing, Nov. 5-7, Hilton Gateway, Orlando. For information: Stephen E. Mattingly, International Medical Education Corporation, 64 Inverness Drive E. Englewood, Colorado 80112.

Glimpses Forward — Clinical Applications of New Diagnostic Imaging and Interventional Techniques, Nov. 11-13, Wolfson Auditorium, Mount Sinai Medical Center, Miami Beach. For info.: Manuel Viamonte Jr., M.D., 4300 Alton Road, Miami Beach 33140, (305) 674-2311.

Advances in External Fixation Nov. 12-14, University of Miami School of Medicine, Miami. For information: Univ. of Miami School of Medicine, Dept. of Oncology, Box J-277, JHMHC, Gainesville 32610. (904) 392-4611.

Update Gastrointestinal Diseases, Nov. 13, Caribbean Gulf Hotel, Clearwater. For info.: Walter W. Hamilton, M.D., Palms of Pasadena Hospital, 1501 Pasadena Avenue, St. Petersburg 33707. (813) 345-9301.

American Heart Association ACLS Course, Nov. 17-19, Naval Regional Medical Center, Jacksonville. For information: Frank J. Kuczler Jr., M.D., Naval Regional Medical Center, NAS Jacksonville 32214. (904) 772-2227.

Advances in External Fixation Nov. 12-14, Univ. of Miami School of Medicine, Miami. For info.: Univ. of Miami School of Medicine, Dept. of Orthopedics (D27), P.O. Box 016960, Miami 33101. (305) 547-6996.

Medical Oncology Grand Rounds, Nov. 19-20, UF College of Medicine, Gainesville. For information: Roy S. Weiner, M.D. Chief of Medical Oncology, Box J-277, JHMHC, Gainesville 32610. (904) 392-4611.

Maxillofacial Pain Symposium, Nov. 20 and 21, Gaineville Hilton, Gainesville. For information: Marvin M. Slott, M.D., 6510 N.W. 9th Blvd., Suite #4, Gainesville 32605, (904) 377-2016.

DECEMBER

Neuro-Ophthalmology, Dec. 2-4, Miami. For information: University of Miami School of Medicine, Dept. of Ophthalmology (D-880), P.O. Box 016960, Miami 33101.

ECG Interpretation and Arrhythmia Management, Dec. 3-5, Bahia Mar Hotel, Fort Lauderdale. For info.: International Medical Education Corp., Division of Postgraduate Education, 64 Inverness Drive E., Englewood, Colorado 80112.

Advances in Technology for the Management of Musculoskeletal Disability, Dec. 6-8, Miami. For information: Univ. of Miami School of Medicine, Dept. of Orthopedics (D27), P.O. Box 016960, Miami 33101.

Ultrasound As Used In Modern Obstetrics and Gynecology, Dec. 8-12, Miami Beach. For Information: University of Miami School of Medicine, Dept. of OB/GYN, P.O. Box 016960, Miami 33101.

Human Sexuality, Dec. 9-11, Disney World, Orlando. For info: Pat Taylor, c/o Pedor Bachrach, M.D., 701 E. Semoran Blvd. #108, Altamonte Springs, 32701. (305) 323-7772.

Interamerican Medical Symposium — 3rd Annual Course, Dec. 12-17, Miami Beach. For information: Dept. of Medicine (R760), P.O. Box 016960, Miami 33101.

JANUARY 1983

28th Annual Cardiovascular Seminar, Jan. 7-8, Dolphin Beach Resort, St. Petersburg Beach. For information: Mr. E. Jerry Eatman, P.O. Box 7188, St. Petersburg 33734.

6th Annual Review in Oral Pathology, Jan. 10-14, University of Miami, Miami. For information: University of Miami CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

Grand Prix Road Racing — Medical Aspects, Jan. 12, Peace River Country Club, Bartow. For information: Mrs. Elsie Trask, Exec. Dir., Polk County Medical Society, (813) 682-0543.

Coexistent Pulmonary and Cardiac Disease, Jan. 12, Mount Sinai Medical Center, Miami. For information: Marvin L. Meitus, M.D. and Adam Wanner, M.D., 4300 Alton Road, Miami Beach 33140, (305) 674-2311.

2nd International Advanced Arthroscopic Update, Jan. 12-15, Sand Piper Bay, Port St. Lucie. For info: Ronald S. Grober, M.D., 2000 Nebraska Ave., Fort Pierce 33450, (305) 464-3657.

8th Annual Review and Recent Practical Advances in Pathology, Jan. 17-21, University of Miami, Miami Beach. For information: Univ. of Miami School of Medicine, Dept. of Pathology, P.O. Box 016960, Miami 33101, (305) 325-6437

Acute Spinal Cord Injury — Comprehensive Management, Jan. 19-23, Univ. of Miami, Miami. For information, CME, University of Miami School of Medicine, P.O. Box 016960, Miami 33101, (305) 547-6716.

15th Annual Postgraduate Seminar in Pediatric and Adult Urology, Jan. 19-22, Sheraton Bal Harbor Hotel, Miami Beach. For info: Victor A. Politano, M.D., 6614 Miami Lakes Dr., East, Miami Lakes, 33450, (305) 687-1367.

Continuing Education in Pediatrics - 1983, Jan. 23-27, Diplomat Hotel, Hollywood. For information: Donald H. Altman, M.D., 6125 Southwest 31st Street, Miami 33156. (305) 667-7060.

Round Table Day, Jan. 28, Diplomat Resort, Hollywood. For information: Donald H. Altman, 6125 Southwest 31st Street, Miami 33156. (305) 667-7060.

Symposium on Intensive Care, Jan. 29 - Feb. 5, Vail, Colorado. For info.: University of Miami School of Medicine, P.O. Box 016960, Miami 33101. (305) 325-6726.

Pediatric Nephrology Seminar X, Jan. 30-Feb. 3, University of Miami, Miami. For information: University of Miami, Department of Pediatrics, P.O. Box 016960, Miami 33101, (305) 325-6726.

FEBRUARY

Clinical Approach to Exercise Testing, Feb. 3, 4, and 5, Hyatt Orlando, Orlando. For info.: Stephen P. Glasser, M.D., Univ. of South Florida, College of Medicine, Box 19, 12901 N. 30th Street, Tampa 33612, (813) 974-2880.

Third Annual Treasure Coast Medical-Surgical Review, Feb. 5-6, Dodgertown Conference Center, Vero Beach. For information: John L. Rogers, M.D., Post Office Box 573, Vero Beach 32960, (305) 567-9711.

9th Annual Conference on Anesthesiology, Feb. 5-12, Vail, Colorado. For information: Department of Anesthesiology (R-370), P.O. Box 016960, Miami 33101, (305) 547-6411.

Internal Medicine 1983 - 18th Annual Postgraduate, Feb. 6-11, Miami Beach. For info.: Univ. of Miami School of Medicine, P.O. Box 016960, Miami 33101, (305) 547-6063.

Prostaglandins in Medicine, Feb. 11-12, The Dutch Inn, Lake Buena Vista. For info.: Ms. Grace Wagner, Coordinator, Univ. of Florida CME, JHMH, Box J-233, Gainesville 32610, (940) 392-3143.

10th Annual Homecoming Symposium, February 11-12, Sonesta Bch. Hotel, Key Biscayne. For information: Univ. of Miami School of Medicine, Department of Psychiatry (D-29), Post Office Box 016960, Miami 33101, (305) 325-6335.

Florida Midwinter Seminar in Ophthalmology, Feb. 14-16, West Palm Beach. For info.: University of Miami School of Medicine, Dept. of Ophthalmology (D-880), Post Office Box 016960, Miami 33101, (305) 547-6540.

Florida Midwinter Seminar in Otolaryngology, Feb. 17-19, West Palm Beach. For info.: University of Miami School of Medicine, Dept. of Ophthalmology (D-880), Post Office Box 016960, Miami 33101, (305) 547-6540.

Spine Surgery, Back to Basics, Feb. 28-March 3, Kissimmee. For info.: Univ. of Miami School of Medicine, Dept. of Orthopedics (D-27), P.O. Box 016960, Miami 33101, (305) 547-6996.

Basic Neurology for Psychiatrists and Generalists, Feb. 28-March 4, Miami Beach. For information: University of Miami School of Medicine, Department of CME, Post Office Box 016960, Miami 33101, (305) 547-6716.

MARCH

Breast Disease Update, March 2-6, Mount Sinai Medical Center, Miami Beach. For info.: Lourdes S. Fuenes, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140, (305) 674-2424.

Problems in Rheumatology, March 10-13, Don CeSar Beach Resort Hotel, St. Petersburg Beach. For information: Bernard W. Germain, M.D., Associate Professor of Medicine, Univ. of South Florida, Box 19, 12901 North 30th Street, Tampa 33612, (813) 974-2681.

14th Annual Topics in Internal Medicine, March 17-18, Gainesville Hilton, Gainesville. For info.: Univ. of Florida CME, Box J-233, JHMH, Gainesville 32610, (904) 392-3134.

Recent Advances in Nuclear Medicine Instrumentation, March 24-26, Miami. For info.: University of Miami School of Medicine, P.O. Box 016960, Miami 33101, (305) 547-6716.



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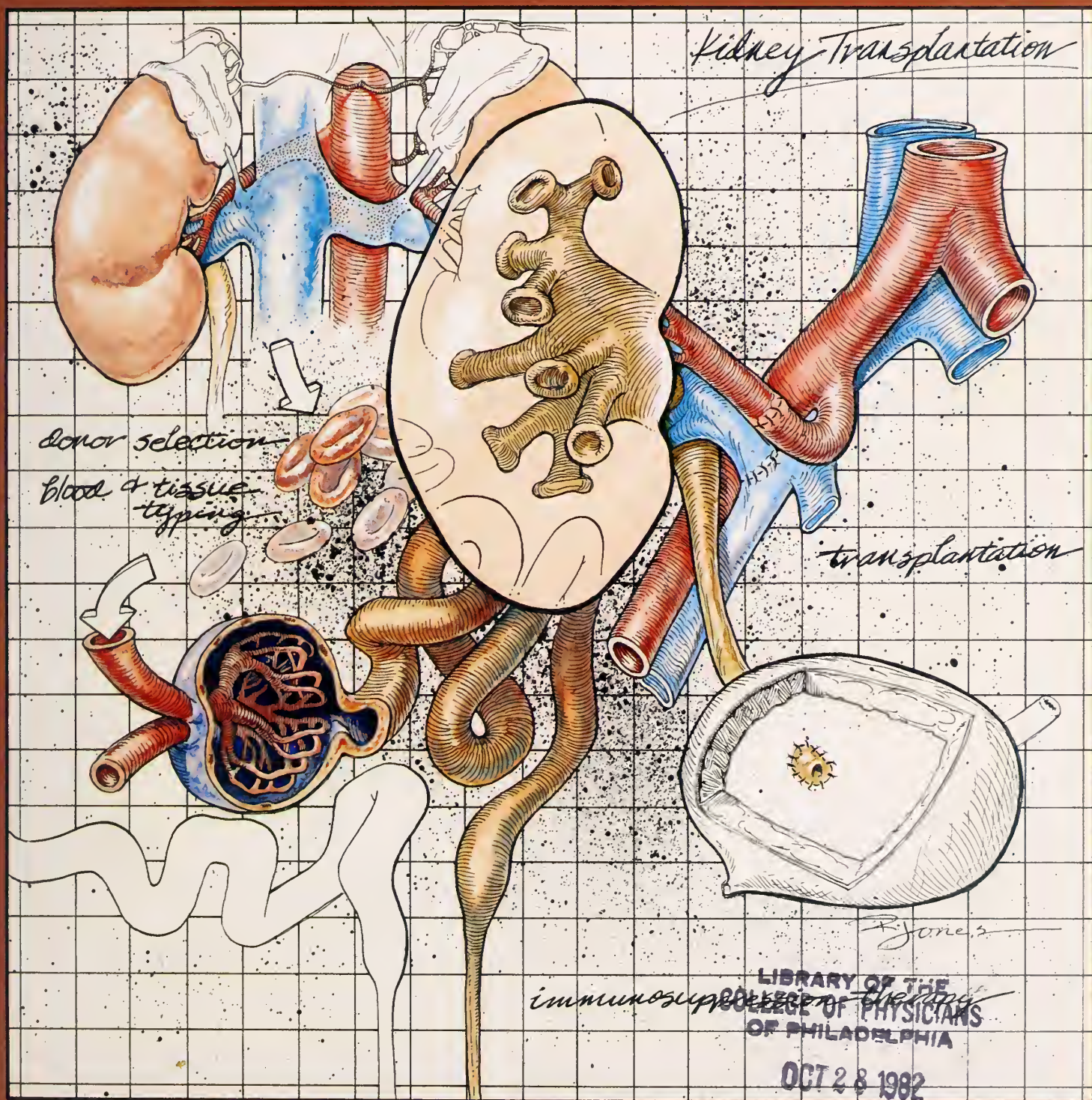
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC. October 1982 Vol. 69, No. 10



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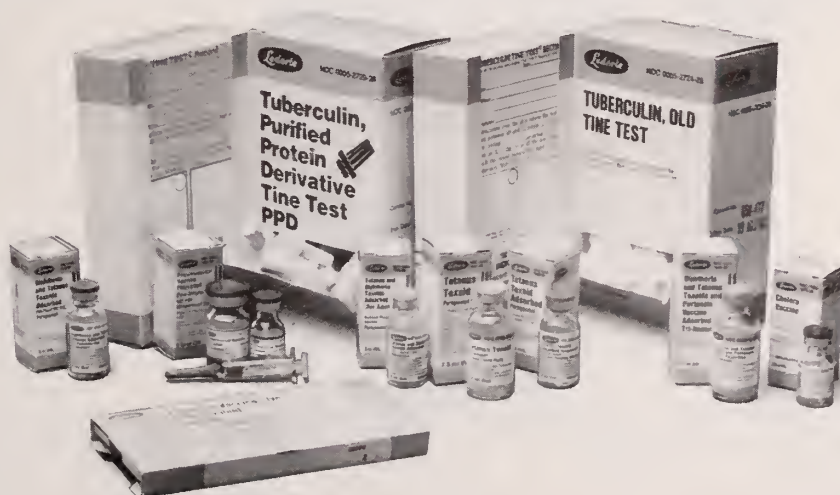
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Before prescribing, please consult complete product information, a summary of which follows:

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Indications: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.

Contraindications: Hypersensitivity to any component.

Warnings: Not for pernicious anemia or other megaloblastic anemias where vitamin B₁₂ is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B₁₂ deficiency who receive supplemental folic acid and who are inade-

quately treated with B₁₂.

Precautions: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

Adverse Reactions: Adverse reactions have been reported with specific vitamins and

5,000,000 hospital patients with infections.⁴ Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.³

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References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease*, op. cit., p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, op. cit., pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med* 89 (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.



minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

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COVER

This month's cover was designed and produced by Mr. Russell G. Jones, a well known medical illustrator who resides in Dallas, Texas. The montage created depicts the various aspects of renal transplantation thus serving as an introduction to the lead article. It begins with donor harvesting, then symbolizes tissue and blood typing, progresses to the operative procedure, and ends with the delivery of immunosuppressive therapy.

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An added complication... in the treatment of bacterial bronchitis*



Brief Summary Consult the package literature for prescribing information.

Indications and Usage: Cefclor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended. As a result of administration of Cefclor, a false positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Use in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in litters given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Use in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefclor.

Hypersensitivity reactions have been reported in about 1.5

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefclor

Pulvules®, 250 and 500 mg

percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefclor® (cefclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). (1002818)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Will it be done?

Long term planning is considered sound practice in business and industry. Even in one's personal life goals are set for the advancing age. However, in the medical profession physicians rarely plan for the future beyond the personal aspects of the office, hospital or faculty setting. Is this as far as we should go, or should we involve ourselves in planning for the future course of our profession?



If you look back at how the profession was perceived and how it performed when you were first starting practice, and compare it with those same parameters today, do you see a change? Of course, the answer will vary based upon the time element involved. Whatever that time is, however, multiply it proportionately to project 50 years from now and what might you expect?

Some might ask "Why should I plan for the future of my profession — that's a job of the hired hands who work for the organization." To follow that course prevents input from one who knows what it means to be a physician. To relinquish that responsibility to primarily non-physicians defeats the purpose. Much of what has occurred over the past decade which affects medical practice has not been the doing of physicians. Should we let this continue?

Almost every physician-oriented publication of late has an article or reference to the concern of many people about the delivery of medical services. Some relate to the virtual loss of a close doctor-patient relationship. Doctors are perceived by some as cold, impersonal — concerned only with a task or procedure, not concerned about the anxiety of the patient. Consequently, many patients expect cold, impersonal results, but they want perfection in their results just like they do when their automobile is repaired. Dissatisfaction leads to unrest which fosters the generation of liability suits. That's a major reason why it's projected that 25% of Florida physicians will be sued next year.

Arnold Relman, M.D., Editor of the *New England Journal of Medicine*, recently spoke to the Board of Regents of the American College of Physicians. He expressed concern over the future by saying "Physicians risk losing the public's confidence if

they don't resist the 'entrepreneurial' trend in medicine. Physicians still hold the keys, but unless they reject entrepreneurialism, medicine will lose its function as an independent and self-regulated profession."

We all recognize the tremendous advances made in technology that enable us to practice better medicine. We look forward to future improvements and advances, yet should we not work equally hard to enhance our relationships with our patients? Are we not obligated to explain our diagnostic and therapeutic efforts to them rather than assume that they understand all?

We cannot afford to relinquish enhancing the art of medicine as we eagerly welcome the progressive scientific advances in medicine. We must remember that the coveted rapport between a physician and his patient is essential for him to be a "complete physician."

The Florida climate in medical practice differs from many other states. Our rapid increase in population is accompanied by a greater increase in physician population. Already data show that in the past decade there has been a decrease in medical services rendered per physician with an increase in physicians income. What this means to the general public may reflect what Dr. Relman is saying.


The opportunity exists and the time still allows us to mobilize our efforts and the ingenuity to look at the future of our society and how our profession should relate to it. Will we take the advantage or will we let it pass us by? In answer to that is the responsibility of each and every physician. We cannot pass the buck and expect favorable results.

I feel confident that there are enough of us out there to accept this obligation to preserve the high standards of our profession. Let's start working together, one and all, to make our long range plans. Will it be done?

Robert E. Wadson, M.D.

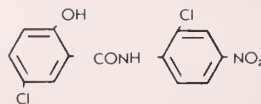
P.S. Our AMA member ranks continue to increase, thanks to those of you who have helped recruit new members. If you haven't got yours yet, keep trying.

Now available in the United States From Miles Pharmaceuticals



The scolex (below) has two elongated sucking grooves; the body (in background) may have as many as 4,000 proglottids.

DESCRIPTION: NICLOCIDE (niclosamide) is an anthelmintic provided in chewable tablet form at a strength of 500 mg per tablet. Niclosamide is 2', 5'-Dichloro-4'-nitrosalicylanilide. The empirical formula is $C_{11}H_6Cl_2N_2O_4$ with the following structural formula



CLINICAL PHARMACOLOGY: NICLOCIDE inhibits oxidative phosphorylation in the mitochondria of cestodes. Both *in vitro* and *in vivo*, the scolex and proximal segments are killed on contact with the drug. The scolex of the tapeworm, loosened from the gut wall, may be digested in the intestine, and thus may not be identified in the feces even after extensive purging. The use of NICLOCIDE has not been associated with the development of anemia, leukopenia or thrombocytopenia nor have there been any effects on normal renal and hepatic functions.

INDICATIONS AND USAGE: NICLOCIDE (niclosamide) is indicated for the treatment of tapeworm infections by *Taenia saginata* (beef tapeworm), *Diphyllobothrium latum* (fish tapeworm) and *Hymenolepis nana* (dwarf tapeworm).

CONTRAINDICATIONS: NICLOCIDE™ Tablets are contraindicated in individuals who have shown hypersensitivity to any of its components.

PRECAUTIONS: NICLOCIDE affects the cestodes of the intestine only. It is without effect in cysticercosis.

Drug Interactions: No data are available regarding interaction of niclosamide with other drugs.

Carcinogenesis, Mutagenesis, Impairment of fertility:

Carcinogenicity Potential: Although carcinogenicity studies on niclosamide *per se* have not been done, long-term feeding studies on its ethanolamine salt in rats and mice did not show carcinogenicity. Mutagenicity tests have not been performed.

Pregnancy: Pregnancy Category B: Reproduction studies in rabbits and rats at doses of 25 times the human therapeutic dose and in mice at 12 times the human therapeutic dose, have revealed no evidence of impaired fertility or harm to the fetus due to niclosamide. There are, however, no adequate and well-controlled studies in pregnant women. Because animal studies are not always predictive of human response, the drug should be used during pregnancy only if clearly needed.

Nursing Mothers: No studies are available.

Pediatric Use: In children under 2 years of age, the safety of the drug has not been established.

ADVERSE REACTIONS: The incidence of side effects has been reported as follows: nausea/vomiting 4.1%, abdominal discomfort including loss of appetite 3.4%, diarrhea 1.6%, drowsiness, dizziness, and/or headache 1.4%, and skin rash including pruritus and 0.3%. Other side effects listed in decreasing order of frequency were: oral irritation, fever, rectal bleeding, weakness, bad taste in mouth, sweating, palpitations, constipation, alopecia, edema of an arm, backache and irritability. There was also one instance of a transient rise in SGOT in an i.v. narcotic addict. Two cases of urticaria reported may be

related to the breakdown products of the tapeworm. All side effects were mild or moderate and transitory and did not necessitate discontinuation of the treatment.

OVERDOSAGE: Insufficient data are available. In the event of overdose a fast-acting laxative and enema should be given. Vomiting should not be induced.

dosage and administration:

1. *Taenia saginata* and *Diphyllobothrium latum*

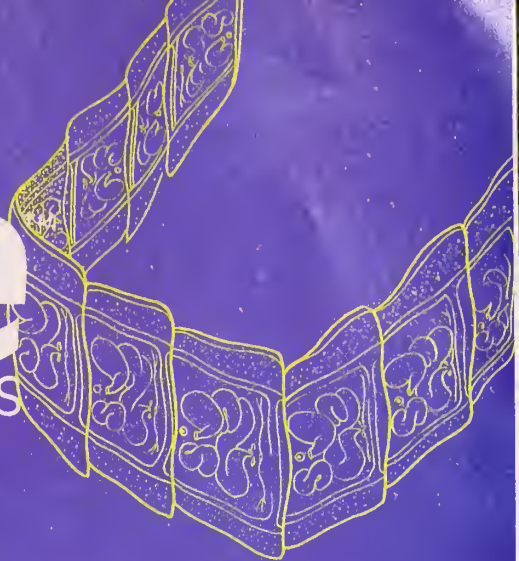
- Adults: 4 tablets (2.0 g) chewed thoroughly in a single daily dose for 7 days.
- Children weighing more than 34 kg (75 lbs): 3 tablets (1.5 g) chewed thoroughly in a single dose.
- Children weighing between 11 and 34 kg (25 to 75 lbs): 2 tablets (1.0 g) chewed thoroughly in a single dose.

2. *Hymenolepis nana*

- Adults: 4 tablets (2.0 g) chewed thoroughly as a single daily dose for 7 days.
- Children weighing more than 34 kg (75 lbs): 3 tablets (1.5 g) chewed thoroughly on the first day, then 2 tablets (1.0 g) daily for next 6 days.
- Children weighing between 11 and 34 kg (25 to 75 lbs): 2 tablets (1.0 g) to be chewed thoroughly on the first day, then one tablet (0.5 g) daily for next 6 days.

T. saginata and *D. latum* infections are usually due to a single adult worm and require an intermediate host in their life cycle. With *Hymenolepis nana* multiple infections are the rule. No intermediate host is required; both larval and adult stages of the worm may be found in the human intestine where the complete life cycle occurs. Since the drug is more effective against the

NEW Prompt-Action **NICLOCIDE** NICLOSAMIDE CHEWABLE TABLETS 500 mg.



A safe, reliable single-dose taeniocide that eradicates beef and fish tapeworms in a single day

Highly effective prompt taeniocidal action

NICLOCIDE™ (niclosamide) is considered as the drug of choice in eliminating beef tapeworm (*Taenia saginata*), fish or broad tapeworm (*Diphyllobothrium latum*), and dwarf tapeworm (*Hymenolepis nana*) from the intestines. Except for the dwarf tapeworm, which requires a seven-day treatment (SEE FULL PRESCRIBING INFORMATION BELOW), a one-day single-dose treatment is sufficient to kill these cestodes.

Breaks hold of head and chain of segments

NICLOCIDE works promptly and simply. After tablets are chewed thoroughly and washed down with a little water (for children tablets should be pulverized and mixed

with a little water), the insoluble micronized crystals act by direct contact on the tapeworm head. As soon as NICLOCIDE reaches the parasite, the scolex and upper segments are killed, thus depriving the whole chain of its hold. It is then discharged in stool either in one piece or smaller portions.*

Safe and well tolerated/ little gastrointestinal mucosa irritation

NICLOCIDE has proved exceptionally well accepted by adults as well as children weighing more than 11 Kg. (25 lbs.).

Convenient one-day single-dose administration†

NICLOCIDE Tablets are taken as a single dose after breakfast.† Tablets must be chewed or pulverized thoroughly and washed down with a little water. No special diet or preparation is necessary except in patients who are constipated. In these cases, a thorough cleansing of the bowels may be required before treatment. The avoidance of alcohol during treatment is the only other requirement.

*A drastic saline purge, such as magnesium sulfate or sodium sulfate should be given two hours after the NICLOCIDE dose if it is required that the tapeworms be expelled rapidly and in one piece.

†In infections with beef tapeworm (*T. saginata*) and fish tapeworm (*D. latum*) one single dose is sufficient; for infections with dwarf tapeworms (*H. nana*) a seven-day treatment is recommended (SEE FULL PRESCRIBING INFORMATION ON THESE PAGES).

mature than the larval stage, therapy must be extended over several days to cover all stages of maturation. Patients with *H. nana* must be instructed to observe strict personal and environmental hygiene to avoid autoinfection with this parasite.

3. NICLOCIDE™ must be thoroughly chewed and then swallowed with a little water. No special dietary restrictions are necessary before or after treatment. The best time to take the drug is after a light meal (e.g., breakfast). A mild laxative may be desirable in constipated patients to achieve a normal bowel movement. Young children should have the tablets crushed to a fine powder and mixed with a small amount of water to form a paste.

NICLOCIDE has a vanilla taste which is not unpleasant to most persons.

NICLOCIDE is suitable for administration on an ambulatory or outpatient basis.

4. Follow-up:
As the vermicide action of NICLOCIDE renders the tapeworm, especially the scolex and proximal segments, vulnerable to destruction during their passage through the gut, it is not always possible to identify the scolex in stools. The sooner the tapeworm is passed and examined after treatment, the better the chance of identification of the scolex. Segments and/or ova of beef or fish tapeworm may be present in the stool for up to 3 days after therapy. Persistent *T. saginata* or *D. latum* segments and/or ova on the seventh day post therapy indicate failure. A second identical course of

treatment may be given at that time.

No patient should be considered cured unless the stool has been negative for a minimum of three months.

HOW SUPPLIED: NICLOCIDE is available as round, light yellow chewable tablets, scored on one side, embossed with the word Miles and number 721, each containing 500 mg of niclosamide, and is supplied in boxes of 4 tablets.

Storage Conditions: Store below 86°F (30°C), avoid freezing.

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Distributed by:
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ONE FOR ALL – One tablet treats pinworm
in any patient, regardless of age or body weight.*
Obviates need to calculate individual dosages.

A single tablet eradicates pinworm in 95% of patients.

*Contraindicated in pregnant women and in persons who have shown hypersensitivity to the drug.

VERMOX[®] CHEWABLE TABLETS
(mebendazole)



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The #1 anthelmintic for pinworms and many other worm infestations

Please see complete Prescribing Information on adjacent page.

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(mebendazole)

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each family
member

DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. In man, approximately 2% of administered mebendazole is excreted in urine as unchanged drug or a primary metabolite. Following administration of 100 mg of mebendazole twice daily for three consecutive days, plasma levels of mebendazole and its primary metabolite, the 2-amine, never exceeded 0.03 µg/ml and 0.09 µg/ml, respectively.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS PREGNANCY VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets. VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

US Patent 3,657,267
December 1979

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Because it is metabolized by simple conjugation rather than complex oxidative reactions, Ativan does not compete with other drugs for hepatic P450 microsomal enzymes. Concomitant use with Tagamet® (cimetidine), for example, does not result in delayed clearance or increased sedation†—effects which have been reported with other benzodiazepines.¹⁻⁵

greater control of therapy

The short half-life of Ativan facilitates more rapid response to dosage adjustments, aiding you in titrating therapy to the patient's changing needs. Once you decide to discontinue Ativan, it will be out of your patient's system 4 days after the final dose—unlike the long-acting, multi-metabolite benzodiazepines which take as long as 2 weeks to be totally eliminated.

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References:

- 1 Klotz U, Reimann I. N Engl J Med 302:1012-1014, 1980.
- 2 Desmond PV, Patwardhan RV, Schenker S, et al. Ann Intern Med 93:266-268, 1980.
- 3 Patwardhan RV, Yarborough GW, Desmond PV, et al. Gastroenterology 79:912-916, 1980.
- 4 Sellers EM, Naranjo CA, Peachey JE. N Engl J Med 305:1255-1262, 1981.
- 5 Ruffalo RL, Thompson JF, Segal JL. South Med J 74:1075-1078, 1981.

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*Pharmacokinetics cannot as yet be directly related to efficacy.

†All benzodiazepines produce additive effects when given with CNS depressants such as barbiturates or alcohol.

See important information on following page.

Ativan®
for (lorazepam) **@**
Anxiety

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g., drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid over-sedation. Terminate dosage gradually since abrupt withdrawal of any anti-anxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown, but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper GI disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia, some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions: If they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levartanol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan®
for (lorazepam)®
Anxiety

Dosage: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

How Supplied: 0.5, 1.0 and 2.0mg tablets.

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AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid 100 mg.
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Thiamine HCL (B-1) 25 mg.
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Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 5 tablets daily.

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Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

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In some parts of the world, large populations are afflicted with helminthic infections. Physicians in endemic areas have become experts on parasitic diseases—and have come to rely on Antiminth for the rapid cure of infestations. Antiminth is recommended as an agent of first choice for pinworm and roundworm by leading medical authorities.³

Warnings

Usage in Pregnancy Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions

Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions

The most frequently encountered adverse reactions are related to the gastrointestinal system. Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

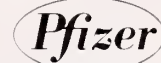
CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration

Children and Adults Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

References 1. Pitts NE, Migliardi JR: *Clinical Pediatrics* 13:87, 1974. 2. Modell W: *Drugs of Choice* 1980-1981. C. V. Mosby Co., St. Louis, 1980, p. 362. 3. Goodman LS, Gilman A: *The Pharmacologic Basis of Therapeutics*, 6th edition, MacMillan Publishing Co., Inc., New York, 1980, p. 1032.



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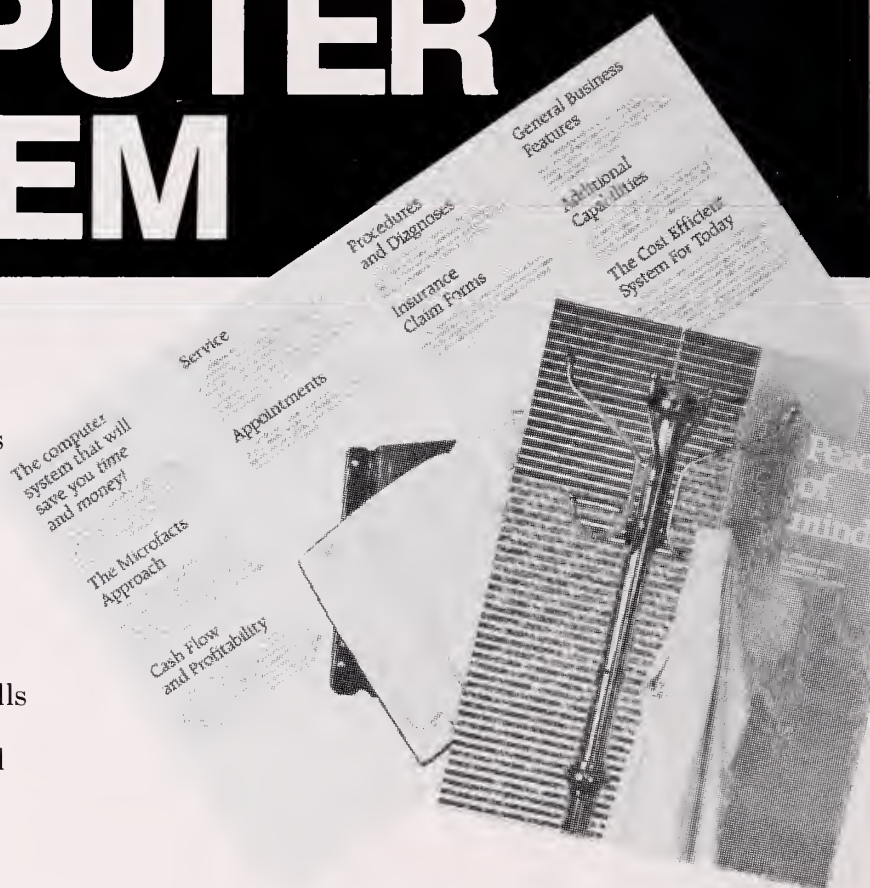
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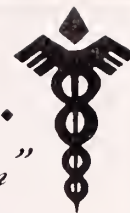


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Learning disabilities the medical profession

I don't know what's the matter with me. I think I'm broken — Arthur, twelve years old.

The above words typify the frustration and concern of a child handicapped by a learning disability. Since the learning disabled child has normal or better intelligence, he can be expected to realize sooner or later that a problem exists for which there is no clear cut explanation or ready solution. Furthermore, without recognition of his handicap and proper training, the disabled child by virtue of his inability to perform and achieve undergoes a process of emotional destruction. The destruction begins with parents and teachers who expect too much, continues with agemates who ridicule and later ignore, and finally ends with the child himself completely devoid of any sense of self worth. Of necessity, the complex and unrelenting nature of the handicapped child's problems (educational, social, emotional) demand an inordinate amount of attention, understanding and patience; hence, the entire family unit is subjected to continual and often increasing stress. The real tragedy occurs either when parents choose to ignore the problem or when they do seek help and are unable to locate anyone familiar with learning disabilities and the resources available for dealing with them.

In researching "Learning Disabilities", which happens to be the Auxiliary's special health project for 1982-83 and the subject of a proposed special issue of *The Journal*, I was fortunate to uncover an excellent publication entitled, "Something's Wrong With My Child — A Parent's Book About Children with Learning Disabilities" by Milton Brutton, Ph.D., Sylvia O. Richardson, M.D. and Charles Mangel. I am sorry to relate that the authors confirmed my suspicion that not only are there few physicians interested and familiar with this subject but also a significant percentage of the medical profession seems undecided whether or not to become involved. As an explanation, it has been suggested that the physician finds himself in an awkward position in dealing with the learning disabled since the treatment is essentially educational. Irrespective of the need for an educational program tailored for each child, I strongly agree with Brutton, Richardson and Mangel that physicians have an important role to play in the management

of children with learning disabilities. Certainly, physicians who treat children should be able to detect the possibility of a learning disorder and be able to offer recommendations concerning the presence of physical and mental disease, appropriate psychological testing, counseling, and educational resources. When one considers the magnitude of this problem (at least 10% of all boys and girls under the age of 18 have a learning disability) and the consequences of neglect (inability to live a productive life — possible psychiatric institutional care, criminal involvement, drug addiction), it is easy to understand why we as both physicians and responsible citizens need to do our part in meeting the challenge.

Daniel B. Nunn, M.D.
Editor
Jacksonville

Medical and ethical guidelines for managing the elderly ill

Primary-care physicians increasingly are confronted with the challenge and complex responsibility of managing older persons over prolonged periods. When they develop superimposed illnesses and emergent disorders, a host of ethical — as well as medical — considerations often are introduced. An attitude of diagnostic or therapeutic nihilism is not infrequent once patients have been categorized as "vegetables."

Over the years, I have adopted some guidelines for my own orientation to this situation. Hopefully, they may be useful to others.

1. A physician must remain alert to the coexistence or development of other conditions in older patients, especially if amenable to treatment. Unfortunately, many risk having their diagnoses "etched in marble" during extended doctoring. This issue was dramatically underscored by a 68-year-old man whose "refractory" fatigue had been attributed to heart failure, pulmonary emphysema and diabetes

mellitus. After a gratifying response to treatment for previously-unrecognized myasthenia, he shot a hole-in-one shot on resuming golf!¹

2. A physician must encourage handicapped patients to function within the prudent limits of their tolerance — whether in the realms of work, hobbies or sexuality. The basis for this perspective is perhaps best crystallized by the expression, "If you don't use it, you lose it."
3. A physician must respect the body's inherent powers for functional improvement before labeling a disorder as "hopeless." Every experienced clinician can recall instances of unexpected partial or complete recovery from severe stroke, myocardial infarction, normal-pressure hydrocephalus, hepatic coma, bacteremic shock, renal failure, and even metastatic malignancy.
4. A doctor must resist pressures against diagnostic or therapeutic intervention from the patient or the family that are based upon "quality of life" misperceptions if he deems such professional efforts to be warranted. The specter of a "vegetable" existence can have a devastating impact on the level of medical care. This matter extends far beyond "pull the plug" decisions relative to life-support systems. In the cited patient, for example, failure to have pursued the diagnosis of myasthenia would have left him an invalid if the previous explanations for his severe fatigue — coupled with that of "old age" — had prevailed.

Physicians increasingly are being urged by their patients to let them "die with dignity." The person may fail to realize the serious implications of this rigid stance. Indeed, I know of instances wherein colleagues were severely restrained by a prior "living will" once the quality-of-life issue had been raised.

Admittedly, numerous factors could influence the conservative management of chronically ill persons. There have been many instances in which I felt that aggressive study and treatment were not warranted.

I have encountered such misplaced resistance even from relatives in the medical profession. Others share this experience. For instance, the physician-son of an elderly lady wrote her nephrologist, "We agreed that her kidney failure was probably both total and permanent, but when you strongly recommended that we should embark on a program of permanent hemodialysis, I was appalled. I could not bring myself to consent . . . but the price incurred was my present vague, perhaps irrational feeling of guilt."²

Doctors must not allow themselves to be diverted from the reasonable pursuit of a potentially treatable disorder by the foregoing quasi-ethical arguments when they are not truly convinced the situation is hopeless. Is it not hypocritical to voice

opposition to abortion, sex preselection or female infanticide on one side of life's spectrum,³ and to deny legitimate medical intervention on the other side chiefly because a person has been defined as "old"? I have witnessed enough worthy contributions by "senior citizens" after their salvage through proper medical care that I feel compelled not to ignore their potential remaining value to society.

There are other conditions in which physicians must not allow themselves to be boxed into "death with dignity" decisions. They involve depression, patient ambivalence or unreasonable fear, and other problems masquerading under the guise of death-with-dignity pleas.⁴ Misconceptions on the part of families and intensive care unit personnel often develop. Rabkin, Gillerman and Rice⁵ cautioned about unwitting consent to an "order not to resuscitate" (ONTR) when such decision-making might be unduly influenced by temporary pain, disease or medication. Jackson and Youngner⁴ wrote

The issues of patient autonomy and the right to die with dignity are without question important ones that require further discussion and clarification by our society as a whole. However, there is a danger that in certain cases, preoccupation with these dramatic and popular issues may lead physicians and patients to make clinically inappropriate decisions — precisely because sound clinical evaluation and judgement are suspended.

Yet another danger confronts the attending physician who does not maintain his objectivity and vigilance under these circumstances. It is suit for purported negligence in a highly litigious society. The doctor must be aware that such action could be initiated by the same persons who had demanded his restraint, perhaps stemming from their sense of guilt.

*H. J. Roberts, M.D.
West Palm Beach*

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anorexia
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and worthlessness
fatigue
palpitations
headache
vague aches
and pains
sadness
psychic and
somatic anxiety

Artist's conception,
looking out from the human eye
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses). Myocardial infarction and stroke reported with use of this class of drugs. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies.

Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated. Sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias in the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdose: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Packs of 50.

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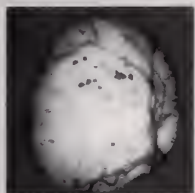
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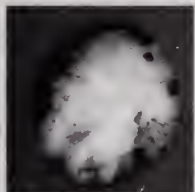
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SYMPTOMS:

EARLY INTERSTITIAL CYSTITIS



CLASSICAL INTERSTITIAL CYSTITIS



- ☐ irritative voiding symptoms
- ☐ suprapubic pain
- ☐ functional bladder capacity reduced
- ☐ anatomical bladder capacity:
EARLY — normal
CLASSICAL — reduced
- ☐ vesical mucosa:
EARLY — normal appearing
CLASSICAL — ulcerated,
scarred
- ☐ submucosal vesical
hemorrhages observed
following second overdistension

DIAGNOSIS: INTERSTITIAL CYSTITIS

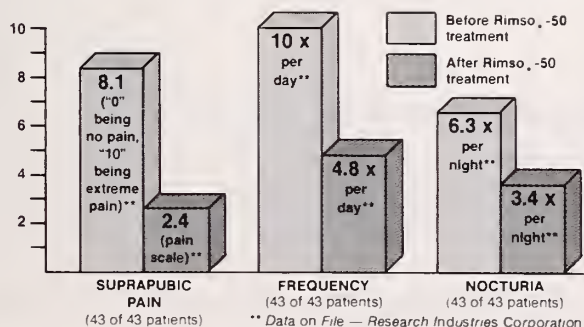
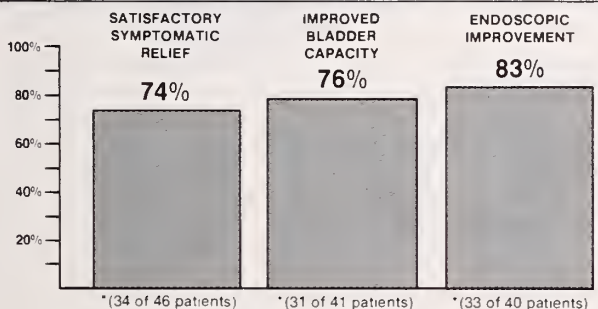
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CONTRAINDICATIONS: None known.

WARNINGS: Dimethyl sulfoxide can initiate the liberation of histamine and there has been occasional hypersensitivity reaction with topical administration of dimethyl sulfoxide. This hypersensitivity has been reported in one patient receiving intravesical Rimso-50. The physician should be cognizant of this possibility in prescribing Rimso-50. If anaphylactoid symptoms develop, appropriate therapy should be instituted.

PRECAUTIONS: Changes in the refractive index and lens opacities have been seen in monkeys, dogs and rabbits given high doses of dimethyl sulfoxide chronically. Since lens changes were noted in animals, full eye evaluations, including slit lamp examinations, are recommended prior to and periodically during treatment. Approximately every six months patients receiving dimethyl sulfoxide should have a biochemical screening, particularly liver and renal function tests, and complete blood count.

Intravesical instillation of Rimso-50 may be harmful to patients with urinary tract malignancy because of dimethyl sulfoxide-induced vasodilation. Some data indicate that dimethyl sulfoxide potentiates other concomitantly administered medications.

Pregnancy Category C: Dimethyl sulfoxide caused teratogenic responses in hamsters, rats, and mice when administered intraperitoneally at high doses (2.5-12 gm/kg). Oral or topical doses of dimethyl sulfoxide did not cause problems of reproduction in rats, mice and hamsters. Topical doses (5 gm/kg first two days, then 2.5 gm/kg - last eight days) produced terata in rabbits, but in another study, topical doses of 1.1 gm/kg days 3 through 16 of gestation failed to produce any abnormalities. There are no adequate and well controlled studies in pregnant women. Dimethyl sulfoxide should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when dimethyl sulfoxide is administered to a nursing woman.

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: A garlic-like taste may be noted by the patient within a few minutes after instillation of Rimso-50 (dimethyl sulfoxide). This taste may last several hours and because of the presence of metabolites, an odor on the breath and skin may remain for 72 hours.

Transient chemical cystitis has been noted following instillation of dimethyl sulfoxide. The patient may experience moderately severe discomfort on administration. Usually this becomes less prominent with repeated administration.

DOSAGE AND ADMINISTRATION: Instillation of 50 ml of Rimso-50 (dimethyl sulfoxide) directly into the bladder may be accomplished by catheter or aseptic syringe and allowed to remain for 15 minutes. Application of an analgesic lubricant gel such as lidocaine jelly to the urethra is suggested prior to insertion of the catheter to avoid spasm. The medication is expelled by spontaneous voiding. It is recommended that the treatment be repeated every two weeks until maximum symptomatic relief is obtained. Thereafter, time intervals between therapy may be increased appropriately.

Administration of oral analgesic medication or suppositories containing belladonna and opium prior to the instillation of Rimso-50 can reduce bladder spasm.

In patients with severe interstitial cystitis with very sensitive bladders, the initial treatment, and possibly the second and third (depending on patient response) should be done under anesthesia. (Saddle block has been suggested).

HOW SUPPLIED:

Bottles contain 50 ml of sterile and pyrogen-free Rimso-50 (50% w/w dimethyl sulfoxide aqueous solution).

Dimethyl sulfoxide is clear and colorless.

Protect from strong light.

Store at room temperature (15° to 30° C).

Do not autoclave.

NDC #0433-0433-05.

*Stewart, B.H. et al., J. Urol., 36:116, 1976

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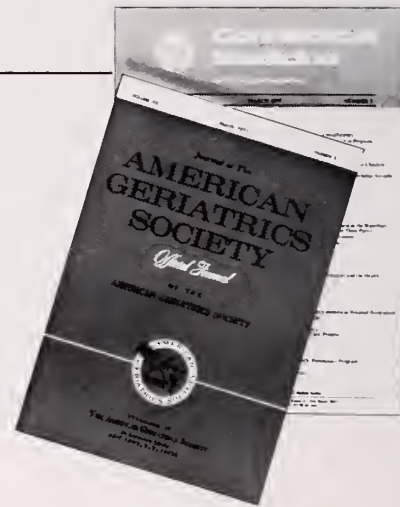
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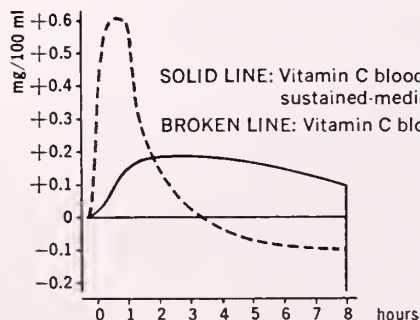
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1. Riccitelli, M.L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20:34, 1972.
2. Riccitelli, M.L.: Vitamin C—A Review. Conn. Med. 39:609, 1975

DEVELOPERS AND SUPPLIERS OF GER-O-FOAM • GAYSAL • B-C-BID

500 renal transplants at the University of Florida, 1966 - 1982

Richard J. Howard, M.D., Ph.D.; William W. Pfaff, M.D.; Robert S. Fennell, M.D.; James J. Mahoney Jr., M.D.; Juan C. Scornik, M.D.; Birdwell Finlayson, M.D., Ph.D. and R. Dixon Walker III, M.D.

ABSTRACT: *Between June 8, 1966 and October 28, 1969, 500 renal transplant procedures were performed at the University of Florida. Two hundred fifty-three transplants were done from related donors and 247 were done from cadaveric donors. There were 435 first transplants, 61 second transplants, and 4 third transplants. For recipients of related transplants, two-year patient survival is 89 percent and graft survival is 75.6 percent. For recipients of cadaveric grafts the two-year patient survival is 72.6 percent while the graft survival is 45.9 percent. Graft and patient survival for recipients of cadaveric grafts for the period 1979-1982 and to 84.4 percent for recipients of kidneys from related donors. We could find no significant differences between graft survival in black and white recipients and could find no difference when patients were divided by age. Recipients of second grafts had a two-year graft survival of 46.3 percent, and two of four third transplants are currently functioning. Improving results of renal transplantation have, we believe, made transplantation the procedure of choice for appropriate patients with end stage renal disease.*

Both renal transplantation and dialysis are accepted methods of treatment for end stage renal disease.^{1,3} Renal transplantation from a cadaveric donor was first done at the University of Florida on June 8, 1966, and on October 28, 1969, the first transplant from a related donor was performed. On April 6, 1982, the 500th renal transplant was performed. This paper is a summary of this experience.

Patient population and methods • Between June 8, 1966 and April 6, 1982, 500 transplants were performed in 436 recipients at the University of Florida (Fig. 1). Our follow up is virtually 100%. Two hundred and fifty-three transplants were done from related donors and 247 from cadaveric donors. There were 435 first transplants, 61 second transplants, and four third transplants. The patients ranged in age from 3 to 61 years.

In the early years of the transplant program at the University of Florida, patients were selected for transplantation on the basis of factors believed to place them in a good risk category. For the past several years, however, more liberal criteria have been used. Some patients have been previously categorized as "high risk."⁴ These categories have included those with diabetes mellitus, collagen-vascular diseases, vascular disease, urinary tract anomalies, enzyme deficiencies, and more than 50 years old. Chronic glomerulonephritis, chronic pyelonephritis, hypertensive nephrosclerosis, diabetes mellitus, and polycystic kidney disease have been the most common disorders for which transplantation has been performed.

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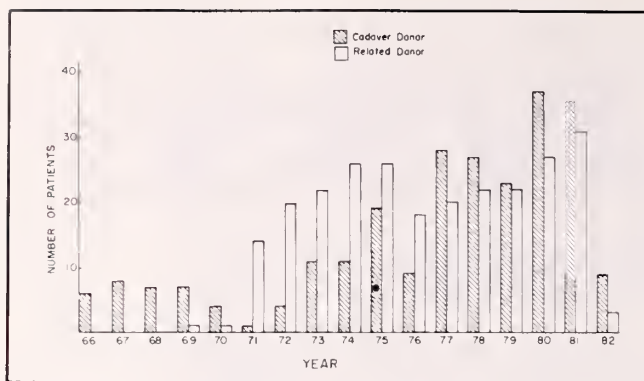


Fig. 1. - Renal transplants by year and donor source. Nineteen eighty-two transplants are through April 6.

Patients referred to the University of Florida have been in various stages of renal failure. Some have been on dialysis for years, while others began dialysis shortly after referral. The median time between onset of dialysis and transplantation was 5.7 months for recipients of kidneys from related donors and 13 months for recipients of kidneys from cadaveric donors. The time between referral and transplantation, however, was shorter for both groups. Patients who have no suitable related donors are placed on a waiting list and are treated with hemodialysis until a suitable cadaveric kidney becomes available. Generally, transplant candidates were accepted if they are between 3 and 50 years old. More recently, however, we have accepted several patients older than 50, believing that apparent physiologic age is more important than chronologic age. Patients have only been ruled out if they have active neoplasm, active infection, cardiac failure not correctable by dialysis, profound pulmonary dysfunction, or inability to comply with the rigorous transplant program. Evaluation prior to transplantation is not complicated. It requires a complete history and physical examination and various laboratory tests, including blood typing and tissue typing. We do a voiding cystourethrogram to look for dysfunction of the lower urinary tract.

Renal transplants have been performed by using vascular techniques first developed by Alexis Carrel in the early 1900s. The kidney is placed in the iliac fossa with vascular anastomoses to the iliac vessels. A ureteroneocystostomy is then constructed. Immunosuppression has generally remained stable throughout the period with prednisone and azathioprine forming the backbone of therapy. We did perform a trial of intramuscular antithymocyte globulin from 1973 to 1975. For the past three years we have been treating patients with rabbit antihuman thymocyte serum intravenously during the immediate post-transplant period. For the past two years, we have been administering blood transfusions prior to the transplant procedure for all recipients with a low level of preformed antibodies against a random panel

of lymphocyte donors. We do not generally perform nephrectomy or splenectomy prior to transplantation. The main indication for nephrectomy now is reflux with a history of urinary tract infections. We are doing fewer nephrectomies for hypertension, polycystic kidney disease, or reflux in the absence of a history of pyelonephritis.

Results • This paper includes all patients and grafts surviving as of July 1, 1982 (four months to 16 years follow up). Actuarial (Kaplan-Meier) methods were used to construct cumulative survival curves for patient and graft survival. Statistical comparisons are done by the log-rank method. Loss of graft is defined by return to maintenance hemodialysis or death. Grafts lost for any reason including technical failures and death of the patient are included in the analysis. All causes of death are included in the survival charts. Death includes patients who rejected their kidney, returned to dialysis, and died while on dialysis.

At the time of this review, 315 (72.2%) patients are alive and 255 (51.0%) have functioning grafts. Of the 435 first transplants, 193 were from cadaveric donors and 242 from related donors.

First transplants — Patient and graft survival for recipients of first related and cadaveric transplants are shown in Figs. 2 and 3. For recipients of related transplants the two year patient survival is 89.0% and the graft survival is 75.6%. For recipients of cadaveric kidneys the two year patient survival is 72.6% while the graft survival is 45.9%. Figures 4 and 5 divide the related and cadaveric graft survival into three time periods, 1966 - 1972 (1969 - 1972 for grafts from related donors), 1973 - 1978, and 1979 - 1982. Graft survival increased for recipients of cadaveric grafts from 30.9% to 35.6% in the periods 1966 to 1972 and 1973 to 1978 respectively, and to 62.8% for the more recent period 1979 to 1982.

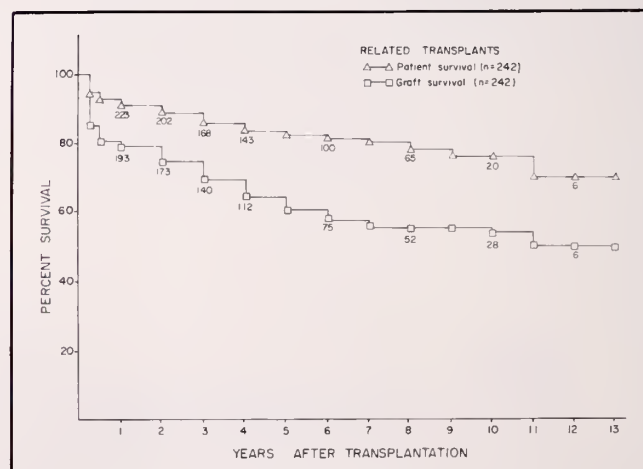


Fig. 2. — Graft and patient survival in recipients of related grafts.

For transplants from related donors, graft survival at two years increased from 65.7% for the 1969-1972 period to 73.2% for 1973-1978 and 84.4% for 1979-1982 period. These increasing graft survivals are significantly different ($p < 0.005$ for cadaver grafts and $p < 0.05$ for related grafts). This improved survival can be attributed to several factors. First of all, with time, the transplant team has continued to become better at taking care of these patients, treating rejection in the post-transplant period, and dealing with complications. In addition, in the most recent time period, we have regularly used antithymocyte serum and have begun a protocol of blood transfusions. With the recent (1981) advent of a mandatory transfusion policy in nonsensitized patients not receiving HLA identical grafts, related graft survival has continued to improve. No transplants from related donors (35 patients) performed after December 1980 have been lost to rejection. Only one graft has been lost when the patient died with a functioning graft one year after transplantation; the serum creatinine was 0.8 mg/dl at the time of death.

We evaluated age to determine whether or not that was an important risk factor in graft survival. We divided patients into those less than or equal to 18 years old, 19 to 44 years old, and more than 44 years old. For recipients of grafts from cadaveric donors the two year graft survival in the group less than 19 was 51.6%, while it was 45.7% for those 19 to 44 years old; in the patients more the 44 years old it dropped to 41.9%. While suggesting that older patients do not do as well as younger patients, these differences are not statistically significant. For recipients of related grafts, there were no differences. The two year graft survival for patients less than 19 years old was 72.8% and it was 76.4% for patients 19 to 44. The graft survival was 75.3% for patients more than 44 years old. These survival figures are also not significantly different. We could find no difference in graft survival between white and black recipients whether the graft was from a related or cadaver donor.

We also studied the effect of HLA matching on graft survival. For all 242 first transplants from related donors HLA identical (four antigen match) grafts had significantly ($p < 0.005$) better graft survival (87.3% at two years) than did non-HLA identical grafts (72.1% at two years). In the most recent period of analysis (1979-1982) improving graft survival among non-HLA identical grafts (84.8% at two years) made these differences not statistically significant. This better graft survival can be most readily attributed to routine use of antithymocyte serum and a planned program of pretransplant blood transfusions. We were unable to demonstrate any effect of HLA typing on survival of kidneys from cadaveric donors because we had so few well-matched (three or four antigens) grafts.

Patient survival has also continued to increase over the course of this series. Survival at two years

was 89.0% for recipients of grafts from related donors and 72.6% for recipients of grafts from cadaveric donors for the entire series. Patient survival at two years increased from 77.1% for the 1969-1972 period to 91.6% for the 1979-1982 period for recipients of related grafts ($p < 0.005$). For recipients of cadaveric kidneys the two year patient survival increased from 44.8% at two years post-transplant for the 1966-1972 period to 89.2% for the 1979-1982 period ($p < 0.005$). Thus, the improving graft survival has been accompanied by an improving patient survival.

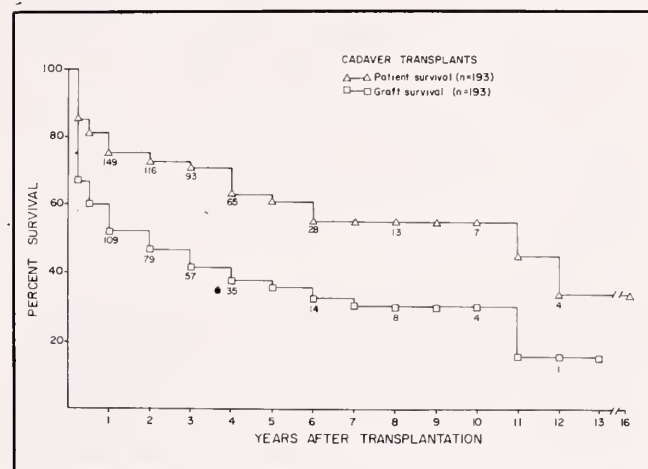


Fig. 3. — Graft and patient survival in recipients of cadaver grafts.

Retransplantation after loss of first graft — Sixty-one patients underwent second transplants after losing their first graft and four patients had third transplants. Of the patients receiving second transplants, 51 were from cadaveric donors and ten from related donors. The two year graft survival for recipients of second transplants from cadaveric donors was 46.3% and for recipients of second transplants from related donors it was 78.7%. For all 61 recipients of second transplants, the two year graft survival was 51.7%. Of the four patients receiving third transplants, all from cadaver donors, two failed after one month and two months and two are currently functioning, one and two years later.

Patient survival two years following second transplants is 83%. It is 80% for recipients of cadaveric kidneys and 89% for recipients of related kidneys. For all 61 patients, the two year patient survival is 83%. Three of the four patients receiving third transplants are currently alive.

Discussion • Transplantation is not a new concept. Indeed, the sphinx (approximately 2600 B.C.) is a xenograft between the head of a human and the body of a lion. The current techniques for vascular suture and transplantation were developed by Alexis Carrel, first in Lyon, France, and then in Chicago and New York in the latter part of the 19th and the early part

of the 20th century. Systematic transplantation in humans began in Boston in the mid- 1950's. Cadaveric transplantation began in 1959 with one transplant performed in Paris, France, and another in Boston. The patient in Boston died in 1979 with a functioning transplant and in 1981 the patient in Paris was still alive with a functioning transplant.⁶

Like all new advances in medicine, transplantation has undergone significant changes since its inception. Although the techniques and immunosuppression employed have been relatively constant, the ability to better select transplant recipients and to treat the complications of transplantation and side effects of immunosuppressive therapy have been better dealt with. Other factors which have come into play during the interval covered by this study is the widespread use of tissue typing, the widespread use of organ sharing among the eastern half of the country, especially in the Southeast, a planned program of blood transfusion, and the routine use of antithymocyte serum.

The relative differences in patient survival and graft function according to donor source are similar to those reported from other centers and from the American College of Surgeons/National Institutes of Health Renal Transplant Registry.^{1,3,7} We also steadily improved our results with time (Figs. 4 and 5). Improved survival has been due in part to routine use of antithymocyte serum, better patient selection, and the program of planned blood transfusions.

Dialysis and transplantation have matured simultaneously as treatments for end stage renal disease. When survival by these two methods has been compared, patients treated by transplantation have had better survival rates than those treated by dialysis.^{1,8} These differences can be further magnified by considering only certain subpopulations such as patients with diabetes mellitus and older patients. Strictly speaking, of course, transplant and dialysis patients cannot be compared,

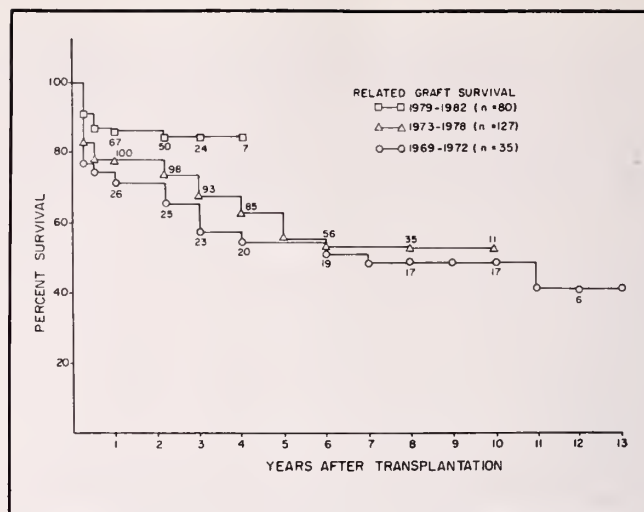


Fig. 5. — Survival of kidney grafts from related donors according to three time intervals.

because transplant recipients are selected from the entire dialysis population and may represent patients who would survive better (or worse) than the group as a whole. Survival following both dialysis and transplantation has improved in recent years.

Other arguments in favor of transplantation over dialysis include: (1) patients no longer need to spend a good part of their day connected to the artificial kidney; (2) transplant patients do not require a restrictive water and dietary regimen; (3) transplant recipients have a better sense of well being than dialysis patients due to correction of the uremia and anemia and the absence of fluid shifts that occur with dialysis. The role of dialysis and transplantation in the treatment of end stage renal disease continues to evolve as both modalities improve, and the final place of each has not been settled.

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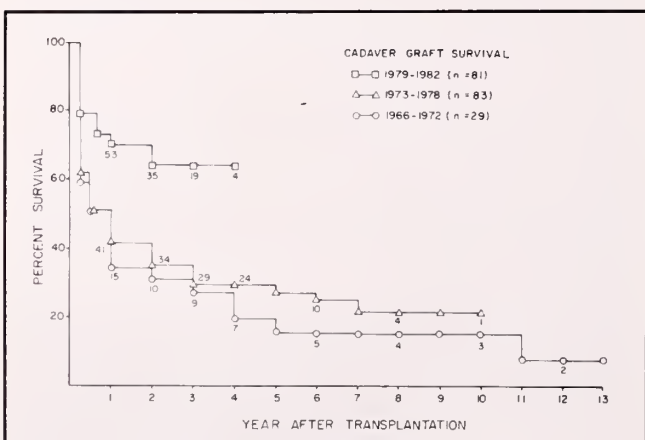


Fig. 4. — Survival of kidney grafts from cadaveric donors according to three time intervals.

Shoes don't "cure" flatfeet

Charles T. Price, M.D.

ABSTRACT: *This article reviews current knowledge regarding flatfeet in children. Despite widespread use of "orthopaedic" shoes for this condition, there is little scientific evidence to justify such treatment. Most flexible flatfeet improve spontaneously giving a false impression of the effectiveness of shoes. Those which do not improve are rarely symptomatic as adults. Radiographs are presented of children's feet taken while barefooted, in orthopaedic shoes and in tennis shoes. Tennis shoes are as effective as orthopaedic shoes for this benign condition.*

Children with flexible flatfeet are seen often in physicians' offices. The problem is so mundane that there seems to be little reason to review the literature concerning this condition. Physicians by the score continue to prescribe "corrective" shoes.^{1,2} A recent survey indicated that 21% of pediatricians, 60% of podiatrists, and 67% of orthopaedic surgeons recommend "special" shoes for flexible flatfeet.² In actual fact there is little evidence to justify this form of treatment.

Clinical findings • The child with a flexible flat-foot pronates when he bears weight. The heel is in valgus and the forefoot is abducted. When sitting or standing on tiptoes the foot assumes a normal shape. The heelcord is not tight. Often there is associated generalized ligamentous laxity. Parents usually bring such a child to the physician between the ages of one and four years. Cosmesis and prevention are the chief concerns. The child is usually asymptomatic unless there is some secondary gain.

Radiographic findings • Roentgenograms made in the standing position in the AP and lateral projection may demonstrate divergence of the talus and the calcaneus. A talar plantar flexion angle of less than 35° is considered normal. An angle of 35-45° represents a mild flexible flatfoot. An angle on more than 45° represents a severe flexible flatfoot. The lateral projection may demonstrate the location of the loss of the longitudinal arch. Bleck found that 52% of children presenting with flat-appearing feet actually have normal x-rays (Fig. 1) representing an anatomically normal low arch.³

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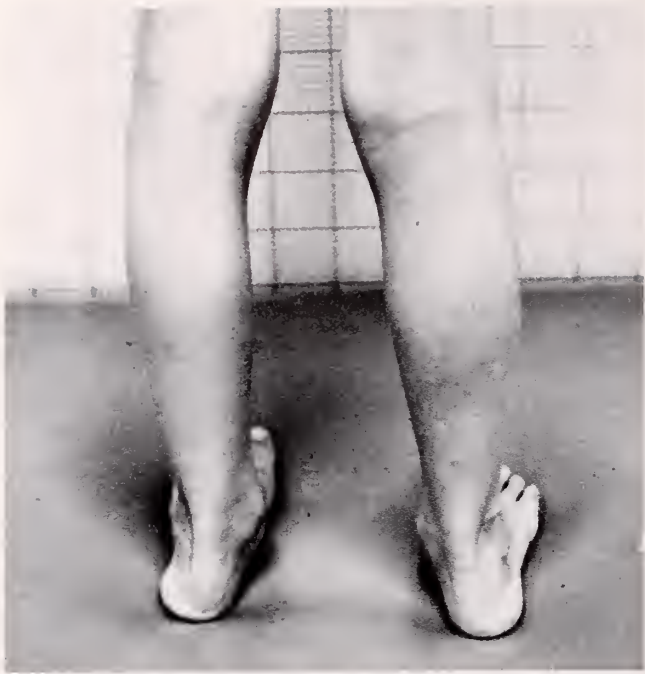


Fig. 1a — "Flatfooted" child standing on soft surface accentuates the degree of pronation.

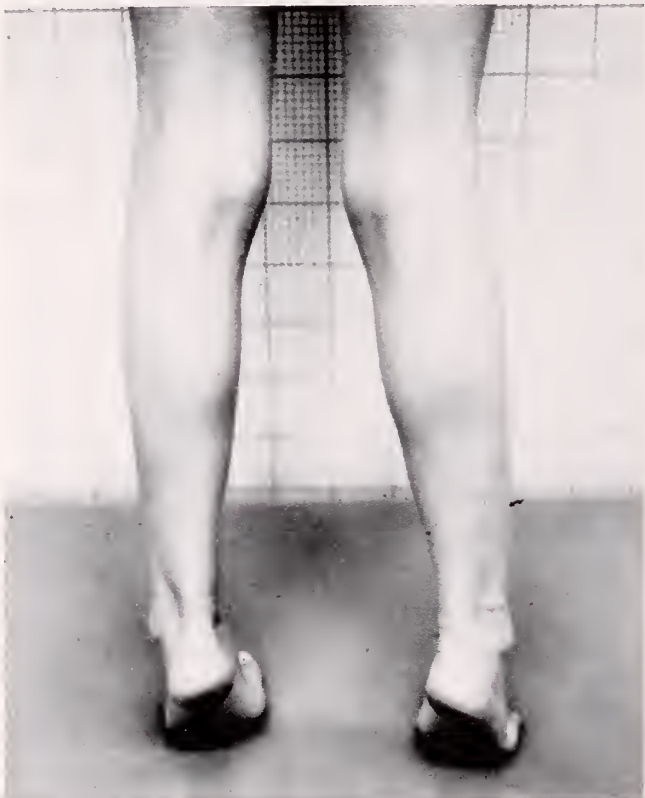


Fig. 1b — Same child standing on tiptoes shows restoration of arch.



Fig. 1c — Lateral x-ray of same child standing shows normal bone alignment consistent with a normal low arch.

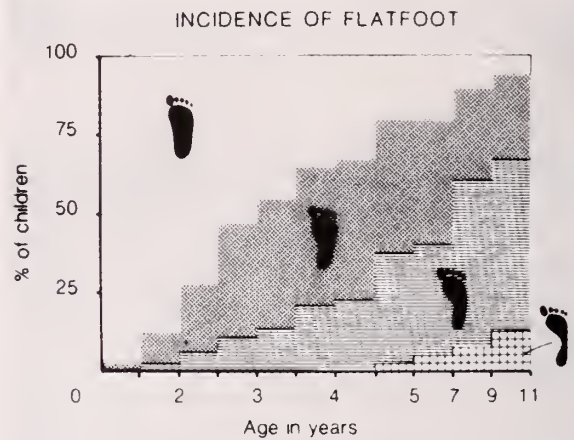


Fig. 2 — This graph illustrates the spontaneous, natural development of an arch with increasing age in untreated children.



Fig. 3a — Heel cup.



Fig. 3b — UCBL orthotic.

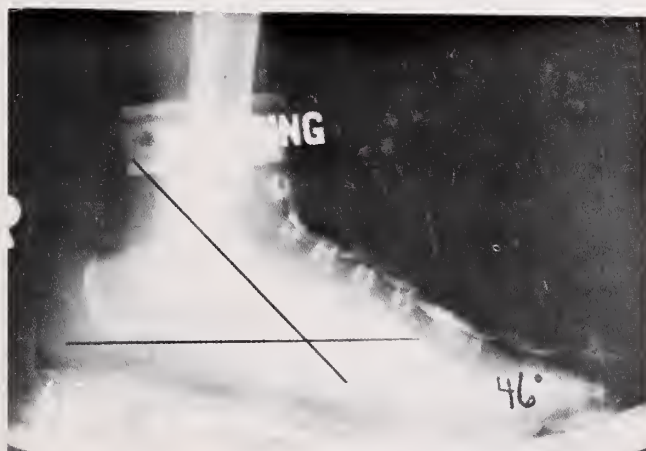
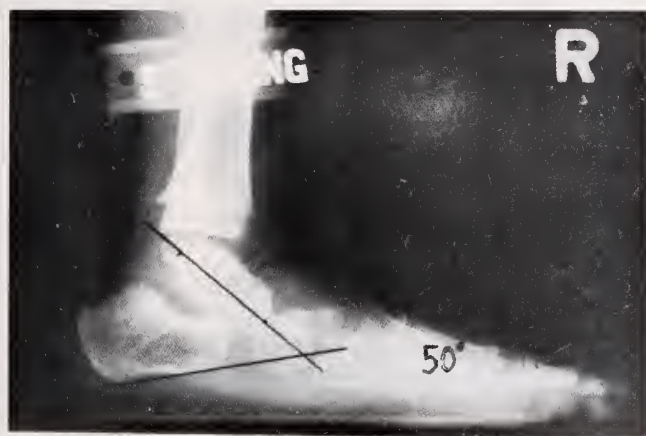


Fig. 4 — Child standing barefooted and in orthopaedic shoe with UCBL insert. Note no significant improvement with orthotic management.



Fig. 5a — Child standing barefooted. Forty-four degree talocalcaneal angle.



Fig. 5b — Same child in "orthopaedic shoe" with 1/8" medial heel wedge, Thomas heel and extra arch support. Forty-three degree talocalcaneal angle.

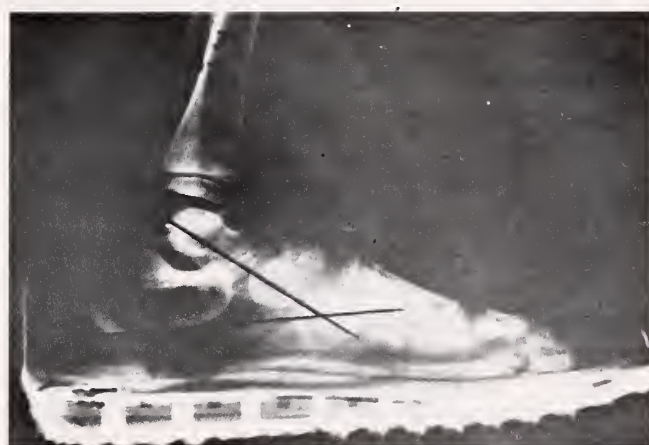


Fig. 5c — Same child shows same or better correction in conventional sport shoe without modifications. Thirty-eight degree talocalcaneal angle.

Natural history ● Morley showed that most young infants have flatfeet due to baby fat obscuring the arch.⁴ In those who develop an arch it usually becomes obvious between the ages of two and six years without treatment (Fig. 2).

In 1944 and 1945 the Canadian Army in Toronto examined, footprinted and x-rayed the feet of 3,619 unselected recruits. The study showed that 22% had flatfeet and most of these were asymptomatic with a normal low arch. Five percent had a mild flexible flatfoot and less than 1% had severe flexible flatfeet.⁵ The authors of the study indicated that severe deformity may be symptomatic but surgical correction is usually successful. The authors further cautioned that it is unwise to perform surgery until late adolescence or early adult life. If mild deformity is symptomatic, pain can be relieved by simple arch supports.

Treatment ● The range of suggested treatments for asymptomatic flexible flatfoot extends from no treatment at all to shoe modifications, inserts and also even includes proponents of early surgery.¹⁵ However, scientific evidence to support any method of treatment is largely lacking.

Sim-Fook and Hodgson compared Chinese who wore shoes to those who did not and demonstrated that walking in bare feet did not give rise to "fallen arches".¹⁶

A comprehensive study of flat-appearing feet in children was conducted by Bleck.³ One thousand children were examined, foot-printed, photographed and x-rayed. Weight bearing molds were made and slow motion gait movies were obtained. Fifty-two percent had an anatomical low arch, 43% had flexible flatfeet and 5% had other conditions. Those with anatomical low arch were not treated. Concerning those with flexible flat feet, he concluded that "this group of children had worn the usual corrective shoes with Thomas heels and medial wedges for five years. These cases still had the clinical and radiographic criteria for pes valgus. The cure rate of this entity appears to be unimpressive. Parents may be pacified by such placebo shoe prescriptions, but the children are likely to be unnecessarily subjected to worthless, unscientific shoeing."³

Two studies do suggest that prolonged use of heel cups or UCBL inserts (Fig. 3) may result in improvement of flexible flatfeet.^{13,14} These inserts may cost up to \$200 and are usually changed every six to eight months as the child grows. Neither study includes a control group and one author has recently become less enthusiastic about this method of treatment.¹⁷

Pennau, et al made radiographs of ten patients with flexible flatfeet while they were barefooted, in "orthopaedic" shoes, in shoes with longitudinal arch supports, in shoes with UCBL inserts and in

shoes with Gillette foot orthosis.⁶ There was no statistically significant difference with any footwear and they concluded that flexible flatfeet in childhood are best treated by educated neglect. The present author has confirmed this study in four additional patients (Figs. 4 and 5).

Discussion ● There is no scientific evidence that shoes of any type can correct flatfeet. Several authors advocate the use of "corrective" shoes but do not provide evidence to support this conjecture.^{1,5,10,11} By contrast, others have demonstrated radiographically and with long term follow-up that shoes do not correct flat feet.^{3,6}

The arch develops naturally with increasing age and more than half of children with flat-appearing feet have normal radiographs.^{3,4} Thus, any form of treatment will lead to a false impression of effectiveness.

The vast majority of adults with flatfeet are asymptomatic.⁵ Less than 5% of flatfooted adults are severe enough to warrant surgery. When surgery is performed, it is generally successful.^{5,18,19} Surgery for asymptomatic children with this condition is not indicated.

It seems that a benign condition which spontaneously improves with age and is rarely symptomatic should not require prophylactic treatment. For the small percentage who become symptomatic in adulthood, arch supports or surgery will be effective in relieving discomfort or deformity.

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Does an intensive care burn unit really make a difference?

A follow-up study

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ABSTRACT: *This is a study of 205 burn patients from the Burn Intensive Care Unit in the University of Florida Medical Center. A comparison of many factors in the management of burn patients at the university is made with the National Burn Information Exchange (NBIE) in Ann Arbor, Michigan, which presents the advantage of large numbers of burn patients and computerized data. Our data shows an average older population and larger percent of body surface burn in both surviving and non-surviving patients. Other comparisons are also made such as cause of the burn, complications, and length of hospital stay. The University of Florida compared favorably with the other NBIE hospitals in most categories except death rate which was higher because of an older age group and a larger percentage of body surface involvement. These two factors are significant predictors of mortality.*

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Seventy patients treated in the Burn Intensive Care Unit of the University of Florida Medical Center in Gainesville have been previously analyzed and tentative conclusions discussed.¹ This present study has the advantage of a larger number of patients reported from the National Burn Information Exchange. The data permit comparison of many factors in the management of 205 patients at the University of Florida facility.

Method • The Burn Intensive Care Unit at the University of Florida Medical Center submits data to the National Burn Information Exchange (NBIE) in Ann Arbor, Michigan. The data as collected from all member units permit a comparison of trends and management in the care of a large number of patients.²

An older population is admitted to the University of Florida unit. Very few patients are below ages ten to 19. Most younger patients are treated in the Pediatric Intensive Care Unit or transferred to a Shrine Burn Center at Galveston, Cincinnati, or Boston.

The smaller number of adolescent admissions also explains the lower percentage of scald burns as compared with other NBIE hospitals (12.3% vs 28.6%) and the higher number of flame burns (79.5% vs 60.0%) admitted to our hospital. It is interesting that 57.9% of the burn admissions occurred from home accidents while 16.5% were work related. One quarter of the admissions were from burns that occurred outside the home and away from work.

Results • One of the most important criteria for predicting survival is the percent of body surface involvement.^{3 4} In comparing this parameter between

the University of Florida and all NBIE hospitals, it is evident that we were dealing with larger burned surface areas. Comparing the 161 patients that survived from the University of Florida with 24,537 patients from NBIE hospitals our average total burn was 25.4% vs 13.6%. The same was true for the 44 patients from the University of Florida who died compared with 2191 patients from NBIE hospitals; our average total burn was 57% and theirs 55.8%. The third degree or full thickness loss also was greater in our series than theirs, 43.3% vs 41.1%.

The survival data on age of patients demonstrated an older population group at our institution with an average of 31.1 years compared to the NBIE age of 26.5 years. Nonsurviving patients were also older (54 years) in our series when compared with the NBIE series (49 years) of average age. An older population combined with a greater surface involvement and a greater full thickness loss in our series resulted in a 21% death rate compared with a 10% rate for NBIE hospitals.

Discussion • The complications that occurred in both series were interesting for the surviving as well as nonsurviving patients.⁵ The incidence of septicemia in which an organism could be identified was identical in both series of survivors at 8%. Clinical sepsis was diagnosed more frequently in the NBIE hospitals than in ours (10.6% vs 3.2%), but pneumonia for our survivors (8.2%) was more common than theirs (4.7%).

The incidence of septicemia and sepsis in our nonsurvivors was greater (25%) than theirs (18.3%). We had more cardiovascular complications (26.9% vs 19.9%) which would be expected from our older population group but the NBIE hospitals had more pulmonary/respiratory complications (14.4% vs 9.6%). The gastrointestinal complications were about the same in both series (1.9%).

Another important criteria that concerns most hospital administrators is length of stay. We compared very favorably with NBIE hospitals on length of stay up to a 40% body surface burn (40.4 days vs 43.7 days); however, at 40% to 50% body surface involvement our patients stayed 84.3 days while theirs stayed 54.3 days, but beyond 50% involvement our patients were discharged 10 to 15 days earlier than the NBIE Hospitals.

When the average stay in the hospital is compared by age, our patients stayed longer but it must be noted again that we were dealing with an older age group that easily had more complications such as cardiovascular deterioration.

The length of hospital stay was more erratic in those patients who died regardless of age but in both groups it was very similar when comparing 10% burn intervals up to 70% total body surface involvement. In the 71% to 80% grouping we had an 83.2 day average stay compared to their 15.5 days of hospitalization. In other words our patients lived longer only to die at a later time.

Summary • This study is an important comparison of the University of Florida Burn Intensive Care Unit with all National Burn Information Exchange Hospitals and demonstrates some significant differences in patient population from age and percent of total body surface involvement. These two factors serve as significant predictors of mortality in the burn patient, and in the present study help to explain the increased mortality of the burn patient in the University of Florida Unit compared with other units throughout the United States.

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Surgical management of hematogenous osteomyelitis of the rib

Armando A. Santelices, M.D., Ignacio L. Fleites, M.D., and Burton H. Harris, M.D.

ABSTRACT: Osteomyelitis of the rib should be considered when planning a biopsy of a chest wall mass. If the lesion is solitary, our experience suggests that wide local excision and a relatively short course of antibiotics can obviate more prolonged treatment.

Rib involvement in hematogenous osteomyelitis is a rare occurrence in children and adults, especially when it is the only lesion. Our recent experience with this disease in an adolescent presenting with a chest wall mass prompts this report.

Case report • A 14-year-old black male was admitted for evaluation of a chest wall mass of three weeks' duration which had become large and painful. The patient denied trauma, had no other symptoms, was afebrile and in apparent good health. The only abnormal finding was a tender, 8 cm mass in the right seventh rib centered over the midaxillary line.

Hemogram, SMAC, urinalysis, and sedimentation rate were normal. Sickle cell preparation and tuberculin skin test were negative. A bone survey showed an overgrowth of bone with irregular densities involving the right seventh rib from the midaxillary line posteriorly to 4 to 5 cm from the costovertebral junction, with associated soft tissue swelling. (Fig. 1). The bone scan disclosed increased uptake only in this area. Chondrosarcoma was considered the most likely diagnosis and the mass was explored.

At operation the rib had multiple fistulous tracts through the cortex and its center contained necrotic material. The lesion was removed en bloc without drainage. Frozen section showed acute and chronic inflammatory changes but a definite diagnosis could not be established. Permanent sections later disclosed chronic osteomyelitis with multiple fistulae. The cultures yielded *Staphylococcus aureus*, coagulase positive, sensitive to all agents except amikacin. The patient was treated with intravenous nafcillin for ten days. His postoperative course was benign.

After discharge he was given oral nafcillin 500 mg every six hours for another week. The wound healed promptly, and six months later he had resumed his normal activities. The most recent rib films, taken two years after operation, showed normal healing in the resected rib with no sign of residual disease.

From the Department of Surgery, University Hospital, Jacksonville, and the Division of Pediatric Surgery, Tufts University School of Medicine, and the New England Medical Center, Boston. This study was supported in part by a grant from the G. William Groh Trust.

Discussion • The best initial management of acute hematogenous osteomyelitis in children remains controversial. Proponents of early exploration or needle aspiration recommend these procedures to confirm the diagnosis, obtain material for culture



Fig. 1. — Rib x-rays of a 14-year-old male with solitary osteomyelitis of the right seventh rib presenting as a chest wall mass.

and antibiotic sensitivity tests, and encourage drainage.¹ Operation was recommended for our patient because of diagnostic uncertainty despite extensive physical, laboratory and radiographic examinations. Resection instead of drainage was elected when chronic infection was found. The

prompt response to our limited therapeutic approach was gratifying.

Hematogenous osteomyelitis of the rib is an unusual condition. Morrey's review of uncommon foci did not include any in this location.² Brock described 17 cases but all his patients had involvement of either the costochondral or costovertebral junction.³ He attributed this to filtration of vascular inflow in these areas. The only comparable patients are reported by Seashore et al⁴ who refer to similar problems of diagnosis in an early case before x-ray changes were apparent and in a late case where a bone tumor was the most tempting diagnosis. They also recommended local removal.

Resection before sequestration is usually unrewarding in osteomyelitis, but in some patients excisional biopsy can be curative. While this approach does not replace antibiotic treatment and is not practical for multiple foci or for the skull or long bones, surgical removal of a solitary lesion can shorten convalescence in appropriate circumstances.

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CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angio-edema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADOVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants: The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin: Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS: Incidence greater than 1%: Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4 to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). Central Nervous System: dizziness*, headache, nervousness. Dermatologic: rash* (including maculopapular type), pruritus. Special Senses: tinnitus. Metabolic: decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100: Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. Central Nervous System: depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma. Dermatologic: vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome and alopecia. Special Senses: hearing loss, amblyopia (blurred and/or diminished vision, scotomata and/or changes in color vision) (see PRECAUTIONS). Hematologic: neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura eosinophilia, decreases in hemoglobin and hematocrit. Cardiovascular: congestive heart failure in patients with marginal cardiac function, elevated blood pressure. Allergic: syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasms (see CONTRAINDICATIONS). Renal: acute renal failure in patients with preexisting significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria. Miscellaneous: dry eyes and mouth, gingival ulcers, rhinitis.

Causal relationship unknown: Gastrointestinal: pancreatitis. Central Nervous System: paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri. Dermatologic: toxic epidermal necrolysis, photo-allergic skin reactions. Special Senses: conjunctivitis, diplopia, optic neuritis. Hematologic: bleeding episodes. Allergic: serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis. Endocrine: gynecomastia, hypoglycemia. Cardiovascular: arrhythmias (sinus tachycardia, bradycardia, and palpitations). Renal: renal papillary necrosis.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Dysmenorrhea: 400 mg every 4 hours as necessary.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for the relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

The newest cephalosporins: how to use them?

N. Joel Ehrenkranz, M.D., and Thomas A. Hoffman, M.D.

The era of the third generation cephalosporins began in the fall of 1981 when cefotaxime (Claforan) and moxalactam (Moxam) became available for physicians' use. Within the next few years more than 20 cephalosporins may be marketed, some with unique properties. Thus, it is proper for a physician to ask: How do the new drugs differ from older ones? How can they best be used? What drawbacks do they possess? It is appropriate for practicing infectious disease clinicians to answer these questions, since drug company sources are likely to provide information from a less critical perspective.

Differences • Cefotaxime and moxalactam differ from first generation cephalosporins (cephalothin, cephapirin, cefazolin, and cephadrine) (Table 1) and from second generation drugs (cefamandole and cefoxitin) in several important aspects: (1) greater range of antibacterial action, (2) greater activity on a weight basis, (3) probable greater likelihood of superinfection and (4) greater cost. Their spectrum of action is expanded and includes *Serratia marcescens*, *Proteus vulgaris*, *Providencia stuarti*, *Morganella morganii* and *Enterobacter* species — microorganisms that are regularly resistant to first generation cephalosporins. Against enteric bacteria susceptible to the older cephalosporins minimal inhibitory concentrations of cefotaxime and moxalactam require five to ten times less drug. Since the new cephalosporins are stable to enzymatic (beta-lactamase) inactivation, they also may inhabit gram-negative isolates that have acquired resistance to the older cephalosporins. However, except for infrequent infections caused by bacteria resistant to older cephalosporins, clinical studies have not shown the third generation cephalosporins to be any more efficacious than the older ones.

The Authors

N. JOEL EHRENKRANZ, M.D.

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Dr. Ehrenkranz is Director, South Florida Hospital Consortium for Infection Control, Inc., and Dr. Hoffman is Chief and Associate Professor of Medicine, Infectious Disease Division, University of Miami School of Medicine.

Indications for Use • Based on in vitro studies, third generation cephalosporins are less potent than the first generation group against gram-positive cocci including *Staphylococcus aureus* and *Streptococcus pneumoniae*. *Streptococcus fecalis* is not susceptible to any cephalosporin. In addition, relatively high concentrations of cefotaxime and moxalactam are required to inhibit *Bacteroides fragilis*, *Pseudomonas aeruginosa* and *Acinetobacter* species. Further, cross-resistance between carbenicillin and a third generation cephalosporin has been noted among isolates of *Pseudomonas aeruginosa*.¹ Third generation cephalosporins have important side effects: superinfection with enterococci and fungi appears to be a fairly frequent occurrence, and prothrombin synthesis can be decreased. Moreover, costs of cefotaxime or moxalactam are approximately five times greater than those of equivalent doses of the first generation cephalosporins and more than double the cost of the second generation drugs. Patient costs will undoubtedly be higher. Charges for third generation cephalosporins given at maximal dosage for 10 days are likely to exceed \$2,500.

Table 1.—Cephalosporin Antibiotics for Parenteral Use.

First Generation	
GENERIC NAME	TRADE NAME
Cephalothin	Keflin
Cefazolin	Ancef, Kefzol
Cephapirin	Cefadyl
Cephadrine	Anspor, Velosef
Second Generation	
Cefoxitin	Mefoxin
Cefamandol	Mandol
Third Generation	
Cefotaxime	Claforan
Moxalactam	Moxam

These considerations dictate that the new cephalosporins be reserved for serious gram-negative infections for which there is no safer and less costly alternative (Table 2). One clear indication is for treatment of a hospital-acquired infection caused by a gram-negative organism that is proved or likely to

be resistant to older cephalosporins, but susceptible to the newer ones. Infections due to *Pseudomonas aeruginosa* or *Acinetobacter* species should generally not be treated with cefotaxime or moxalactam since these antibiotics do not constitute reliably effective treatment. A second indication is for treatment of meningitis due to gram-negative enteric organisms such as *Escherichia coli* or *Klebsiella* species which may arise after head trauma, parameningeal disease or neurosurgery and also may occur in the immunocompromised host or neonate. In contrast to the older cephalosporins, cefotaxime and moxalactam have been shown to penetrate the cerebrospinal fluid sufficiently to be effective in treatment of gram-negative bacillary meningitis.² This is a major therapeutic advance. However, *P. aeruginosa* or *Acinetobacter* species may also be encountered in these situations and meningitis due to either species is unlikely to be eradicated by third generation cephalosporins.

Table 2.—Indications for Use of Cefotaxime and Moxalactam.

1. Serious hospital-acquired infection due to susceptible enteric gram-negative bacilli resistant to older cephalosporins—not for infections due to gram-positive bacteria or microorganisms susceptible to older cephalosporins.
2. Meningitis due to enteric gram-negative enteric bacteria such as *Escherichia Coli* or *Klebsiella* species—not for meningitis due to *Pseudomonas Aeruginosa* or *Acinetobacter* species or gram-positive microbes.

What about use for severe community-acquired infections such as life-threatening abdominal or pelvic infections—with or without bacteremia? It has been suggested that therapy with the newest cephalosporins alone in these conditions is cost-effective. We disagree. Moxalactam by itself has failed in 15% to 20% of serious intraabdominal infections; up to 30% of bacterial isolates from abdominal abscesses were resistant—the most frequent being *S. fecalis*, *P. aeruginosa*, *Bacteroides* and *Clostridial* species.^{3,4} There are reports of fatal *Candida* superinfection complicating moxalactam therapy of intraabdominal infection. Vitamin K administration may be necessary to deal with hypoprothrombinemia and tendencies to excessive bleeding. There is no evidence that any special benefits accrue from use of the newest cephalosporins for community-acquired pneumonias or urinary tract infections, while increased drug costs and risk of superinfection are considerable.

What about use of third generations cephalosporins in surgical wound prophylaxis? Not an indication, and frankly, in our view, an outright abuse. An enormous potential exists for selection and

dissemination of cephalosporin-resistant organisms if widespread use of these antibiotics occurs.

Table 3.—Third Generation Cephalosporins, Advantages and Disadvantages.

Advantages

1. Great potency against gram-negative enteric bacilli.
2. Effective against many more gram-negative enteric bacilli than older cephalosporins.
3. Active against gram-negative enteric bacilli which have become resistant to older cephalosporins.
4. Good penetration of cerebrospinal fluid.

Disadvantages

1. Less effective against gram-positive bacteria than older cephalosporins.
2. May cause serious superinfections with enterococci or fungi.
3. Can cause hypoprothrombinemia.
4. Very expensive.

Conclusion ● The advantages and drawbacks of third generation cephalosporins are summarized (Table 3). In order to prevent misuse and abuse, we strongly suggest some form of hospital limitation. Medical staffs may require a prescribing physician to justify usage according to established criteria. Hospital laboratories need not report third generation cephalosporin susceptibility testing of microorganisms that are susceptible to older cephalosporins, unless a patient with meningitis is being treated. We hope that the Joint Commission on Hospital Accreditation and third party health care payers will regularly seek out evidence of such control.

We anticipate that additional indications for third generation cephalosporins will become evident as results of well conducted comparative studies become available. These studies should show that their greater cost is justified by safely shortening the durations of hospitalization and total care of patients with serious infections.

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United States citizens at foreign medical schools

Richard J. Feinstein, M.D.

Quality of medical care has always been valued as one important measure of the general quality of life in any society. Medical education, for this reason, is part of the national trust, and most medical schools in the U.S., even when privately owned, receive both philosophical and financial support from the government. Of the 126 U.S. medical schools, 75 are public and 51 private, but 38 of those receive some financial support from their state.¹ All states but six have at least one medical school. A primary concern of all schools has been fulfillment of the medical manpower needs of their own state and of the nation as a whole, and medical school admission committees often try to choose applicants who will remain within the state after graduation.

Most nations in the world have at least one national medical school which serves to educate native physicians for the needs of their citizens. Many countries are quite poor and medical education is heavily subsidized with public funds. These countries were encouraged to send their physicians for postgraduate training in the United States, beginning after World War II, when we ended our 20 year period of scientific isolation. Both the U.S. and the physician's native country hoped the trained doctor would return home after his training in the U.S., and many did return to fulfill financial and other commitments to their country. A great number of foreign medical graduates, however, decided to stay in the U.S. where earnings were greater and facilities more advanced. The rapidly expanding U.S. population after the war and creation of new urban and suburban communities cried out for more physicians than the existing medical educational system was capable of producing in any reasonable time. Congress was petitioned to allow foreign physicians to extend their visas and to eventually remain as permanent resident

aliens or citizens. Many states like Florida once required citizenship before a medical license could be granted.

There were 30,900 foreign medical graduates in the U.S. in 1963, 11% of all U.S. physicians, and the number rose to 86,800 in 1977, and 20%.² Medical licensing boards in the U.S. had no idea of the type or quality of medical education those physicians had received, although they granted licensure on demand to those who had attended a World Health Organization listed medical school and then passed two written examinations: Educational Commission for Foreign Medical Graduates test, ECFMG, and the state's own licensure examination, which is presently the Federal Licensing Examination, FLEX, in all 50 states. Almost all medical examinations in the U.S. are prepared by the National Board of Medical Examiners.

The rapidly expanding U.S. population after the war and creation of new urban and suburban communities cried out for more physicians than the existing medical educational system was capable of producing in any reasonable time.

The great majority of foreign medical graduates who sought U.S. licensure had always been foreign nationals, graduates of a medical school in their own nation which had been required to fulfill the educational and licensing requirements of that country. No inspection or accreditation process had ever been implemented in the U.S. to judge foreign medical schools. Listing of all medical schools in the World Health Organization directory was never meant to imply any standard of quality, and schools are listed simply by asking WHO to do so. There are presently about 1,150 schools on the list.

There are close to 100,000 foreign medical graduates in the U.S. but their presence was not perceived

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to be a problem until recently. It was also discovered that many U.S. citizens were seeking medical licensure in the U.S. after medical education at foreign schools, and especially at new schools that had been created for that very purpose. These schools were not created for the traditional purpose of supplying native physicians for the local needs of the resident nation. Some were started by entrepreneurs with funds provided by parents of students and potential students of the school.

It is estimated that there are presently from 12,000 to 16,000 U.S. citizens attending foreign medical schools and about 4,000 will seek medical licensure in the U.S. each year.

It is estimated that there are presently from 12,000 to 16,000 U.S. citizens attending foreign medical schools and about 4,000 will seek medical licensure in the U.S. each year.³ These observations occur at a time when U.S. medical schools are in a serious crisis that has been created by reduction in federal support to medical education, restriction on funding for the care of indigent patients to medical school faculty and others, and a severe restriction of federal and private money for medical research. To compound the crisis, the Graduate Medical Education National Advisory Committee (GMENAC), which was chartered by HEW Secretary Joseph Califano in 1976, recently forecast a surplus of 90,000 physicians by 1990 and an over 200,000 surplus by the year 2000. The GMENAC report urges even further funding restrictions for medical education and has mandated all U.S. medical schools to reduce the size of their 1984 first year class by an equivalent of 18% of the 1978 class size. The plans to force a reduction in size of U.S. medical school classes while 4,000 U.S. citizens from foreign medical schools of uncertain quality seek licensure each year have produced consternation among U.S. medical educators and the general public, and have forced the need for a re-evaluation of the entire process of evaluating foreign medical graduates for licensure and postgraduate education in the U.S. Thousands of foreign national physicians also continue to seek licensure in the U.S. each year.

Pathways for medical licensure • There are prescribed pathways for obtaining medical licensure in the U.S. that are recognized by all state licensing boards.³ These pathways evolved over a period of years in response to the needs of various groups of medical school graduates who sought medical licensure.

The First Pathway is for U.S. citizens who attend a U.S. or Canadian medical school, and this pathway appears to be the most rigorous and competitive. Students must usually excel in high school and college, achieve high grades on the Medical College Admission Test (MCAT), have participated in extra-curricular activities, submit personal recommendations, complete four years of undergraduate medical education at an accredited U.S. or Canadian medical school, one year postgraduate education at an approved program, and complete all three parts of the National Board examination.

There have been rumors for many years about the alleged difficulty that gifted students have in gaining acceptance to a U.S. medical school, with estimates that from 20 to 50 college seniors apply annually for each first year position. Statistics compiled by the Association of American Medical Colleges (AAMC) refute these rumors and show that there have been only two to three applicants for each first year position yearly for the past 40 years.¹ The ratio was highest, 3.5 applicants per position, after World War II when returning veterans sought admission to one of the nation's 79 medical school's 7,000 first year positions. In 1979 there were 2.1 applicants per position to 126 medical schools and over 16,000 first year places. The first year class for 1981-82 was 18,150, and historically the number of applicants to medical school has borne a fairly constant relationship to the number of 22 year olds in the population. If this relationship continues, a gradual decline in the applicant pool can be expected during the 1980's. The GMENAC forecast of a surplus of physicians may reduce even further the number of applicants to medical school. Experience has shown that when the ratio falls much below two applicants per position, the number of well-qualified applicants available for admission to medical school becomes marginal.¹

The Second Pathway for obtaining medical licensure applies to the growing number of U.S. citizens who seek medical education and licensure despite failure to matriculate in a U.S. or Canadian medical school. These students gain entry into a foreign medical school, complete the full medical curriculum and obtain their "titulo" or title of degree as physician. Few foreign medical schools provide medical education or degrees that correspond exactly to the degree granted to graduates of U.S. colleges of medicine. This observation has caused anger among graduates of U.S. colleges of osteopathy who sought, but were denied, an M.D. license from state medical boards. They argue that their medical education is more equivalent to that provided by M.D. granting U.S. schools than the education received by many foreign graduates who are granted an M.D. license in the U.S. A similar argument is uttered by bright U.S. college students who are denied entry into a U.S. medical school, but who point with alarm at the ease with which foreign medical graduates

of uncertain background are allowed entry into the practice of medicine in the U.S.

To follow the Second Pathway, a U.S. citizen who has obtained a titulo must pass the ECFMG examination. One entire portion of this test is devoted to knowledge of English, and is taken from the TOEFL, Test of English as a Foreign Language Examination. The examination is particularly easy for U.S. citizens and others whose native language is English, yet about 50% of U.S. citizen graduates of foreign medical schools fail each year. The overall pass rate for all ECFMG exam takers is 30%. The AAMC has questioned whether the ECFMG test is adequate to serve the purpose for which it is being used — as a test of the readiness for graduate medical education, and as an adequate safeguard of the health and welfare of patients.⁵

After successful completion of the ECFMG test, the student is eligible to take the state's own medical licensing examination, which is presently FLEX in Florida as elsewhere. After completion of one year's internship at an approved program, or proof of five years' continuous practice in any other state or country where the physician already holds a valid medical license, the doctor is granted a medical license.

There have been rumors for many years about the alleged difficulty that gifted students have in gaining acceptance to a U.S. medical school, with estimates that from 20 to 50 college seniors apply annually for each first year position.

The Third Pathway to medical licensure is utilized by a U.S. citizen graduate of a foreign medical school who obtains a titulo, and then enters an approved graduate training program in the U.S. which leads to eligibility and certification by an AMA approved specialty board. Passage of a specialty board examination eliminates the need for the ECFMG test, and the doctor can take the FLEX and obtain a license.

The Fourth Pathway is entered when a U.S. citizen at a foreign medical school seeks transfer to an accredited U.S. or Canadian medical school. This process was formerly called Coordinated Transfer System (COTRANS) and is usually attempted after the second year of school. Students must take the Medical Sciences Knowledge Profile Examination (MSKP), which is prepared by the National Board of Medical Examiners and administered by the Association of American Medical Colleges, the AAMC. This test is equivalent to Part I of the National Board test and is devised to assess the student's knowledge of

basic sciences as learned from the first two years of medical school.

The Fifth Pathway is entered by U.S. citizens who complete the study of work at a foreign medical school but leave before receiving a titulo. This pathway exists primarily for U.S. citizens attending medical school in Mexico where a titulo is granted only after completion of a fifth year, during which the graduate is expected to provide free medical care to poor patients in rural areas. Most U.S. citizens leave after the fourth year. They have been allowed to enter selected postgraduate programs in the U.S. at medical school affiliated hospitals approved by the Liaison Committee on Medical Education (LCME). The physician is then eligible to take the ECFMG and the FLEX in order to obtain a medical license, despite his failure to present a titulo.

The Sixth Pathway to licensure exists for foreign nationals who have graduated from a foreign medical school. Public Law 94-484, the 1976-77 amendments to the Immigration and Naturalization Act, requires that foreign national physicians entering the U.S. must have passed Parts I and II of the National Board test or an equivalent test before being granted a visa for entry.⁶ The Visa Qualifying Examination, (VQE) is prepared to fulfill the intent of that law. The AAMC has called the difference between the ECFMG test for U.S. citizen foreign medical graduates and the VQE for alien physicians indefensible, representing a severe bias against alien physicians who may have attended the same medical schools as their U.S. citizen counterparts. The VQE is administered by the ECFMG only to alien physicians who have precertified in English by passage of the ECFMG English Test or the TOEFL. Those who pass the VQE, and the passage rate is very low, can take FLEX to obtain full licensure.

United States medical schools • At the beginning of the 20th century, there were 160 U.S. medical schools, yet less than 10% of practicing physicians have graduated from anything that we now consider a medical school.² The AMA and the AAMC decried the quality of medical care provided by most physicians and the variable and uncertain quality of medical education. They influenced the Carnegie Foundation to commission Dr. Abraham Flexner to study and report on the condition of medical education in the U.S.

Dr. Flexner's report was published in 1910. It represented a severe blow to the corrupt and proprietary schools that were flooding the nation with incompetent medical practitioners. About one third of the schools that existed in 1904 were closed by 1920 and the number of medical graduates dropped from 6,000 to 2,900. The number of U.S. graduates did not reach 6,000 again until 1951.

U.S. medical schools have evolved since the Flexner Report as highly structured and regulated institutions that must fulfill four obligatory goals

in order to continue to thrive: (1) Provide a good basic medical education for the undergraduate medical students; (2) Attempt to advance medical knowledge through research endeavors; (3) Provide graduate medical education to produce medical practitioners, researchers, and teachers, and (4) Provide facilities and access to continuing medical education for all physicians within the medical school community. The 126 U.S. medical schools all share common general goals, but each has evolved to meet local and regional goals within the framework of their own peculiar circumstances.¹

All U.S. medical schools must pass a thorough inspection and accreditation process that is performed periodically by the Liaison Committee on Medical Education. Schools must complete a lengthy questionnaire and submit to a four to seven day on-site inspection, at their own expense, during which time basic science and clinical facilities are inspected, including library and laboratories, and lengthy discussions held with students and faculty members. State medical boards will not grant a medical license to a graduate of a U.S. medical school that has not been accredited by the LCME.

Foreign medical schools • Many foreign medical schools have a policy of open enrollment and allow admission to all students who apply, including those with no college or high school certificates. It is not uncommon for a first year medical school class in Europe or Latin America to have 15,000 or more students. The schools depend on an attrition of students from massive examination failures over the four year curriculum in order to obtain a graduating class of reasonable size. Some foreign medical schools, especially the new off-shore schools that conduct classes in English, actively recruit U.S. college students by the use of advertisements in campus newspapers. Students are not expected or encouraged to personally visit the medical school and may even be discouraged from doing so for fear of their disappointment at seeing the usually unimpressive physical plant and absence of hospital.

Many foreign medical schools have a policy of open enrollment and allow admission to all students who apply, including those with no college or high school certificates.

Between July and November 1979, representatives of the U.S. General Accounting Office (GAO) visited six foreign medical schools that were known to have U.S. citizen students.⁴ The six had a combined total

enrollment of 5,400 U.S. citizens, which was thought to represent about half the U.S. citizens at foreign medical schools. Others give estimates that as many as 16,000 U.S. citizens may be attending foreign medical schools.³ The schools visited were: Universidad Central del Este in San Pedro de Macoris, Dominican Republic; Universidad Nordestana in San Francisco de Macoris, Dominican Republic; St. George's University School of Medicine in Grenada, West Indies; Universidad Autonoma De Guadalajara in Guadalajara, Mexico; Universita Degli Studi Di Bologna in Bologna, Italy; and Universite de Bordeaux in Bordeaux, France. The first three listed, the Caribbean or off-shore schools, had a total enrollment of 4,100, with 3,100 of those U.S. citizens. The three were less than ten years old and two were less than four years old.

The GAO learned that many U.S. citizens at foreign medical schools obtained part or all of their undergraduate clinical education at U.S. hospitals under arrangements made by either the foreign medical school or the students themselves. They found that none of the foreign schools visited offered a medical education comparable to that available in the United States because of the severe deficiencies in admission requirements, facilities and equipment, faculty, curriculum, and clinical training. The most serious shortcoming at all schools visited was the lack of adequate clinical facilities and in no instance did the school have access to the same range of clinical facilities and numbers and mix of patients as a U.S. medical school. The Secretary of the Department of Health and Human Services identified similar deficiencies in the education of U.S. citizens at foreign medical schools in a report to Congress on May 13, 1980.

Most U.S. citizen foreign medical students try to obtain undergraduate clinical education at U.S. hospitals and the type, length, and extent of that training was not comparable to the training provided to U.S. medical students. Most U.S. hospitals utilized for foreign students are community hospitals which could give no assurance to the GAO that the student clerks were receiving an adequate clinical educational experience. The Liaison Committee on Medical Education which accredits U.S. medical schools also accredits clinical training programs offered by affiliated hospitals. No such organization oversees the clinical training offered to U.S. citizen foreign medical students at community hospitals in the U.S. State medical licensing boards in California, New York and Florida had not approved nor were even aware of clinical training of foreign medical students at hospitals within their own states.⁴

Solutions: The New York State Plan • New York, which along with Florida and California, has the greatest number of residents who are U.S. citizen

foreign medical students and the largest number of students who seek clinical educational clerkships at community hospitals and state medical licensure, took an independent action on March 30, 1980. It amended the regulations of the Commissioner of Education with respect to hospital clerkships and also addressed the problem of medical licensing requirements for foreign medical graduates.

The New York state action requires all clerkships by foreign medical students to be performed only at teaching hospitals in which an approved postgraduate training program exists which corresponds to the subject of the student's clinical clerkship. The residency program at the hospital must be one approved by the Accreditation Council on Graduate Medical Education (ACGME). No student will be allowed to attend an approved clinical clerkship until he has scored a satisfactory grade on the Medical Sciences Knowledge Profile examination (MSKP).

The student, in addition, must be enrolled in a foreign medical school that has been approved by the New York State Department of Education. In order to be approved, the school must forward appropriate documents in English for review, and the school must be willing to submit to on site inspections by persons from the New York State Board of Medicine, at the school's expense.

In order to be eligible for medical licensure in New York state, graduates of foreign medical schools that have not been registered with the state shall complete at least three years of postgraduate training at a program approved by the ACGME or the American Osteopathic Association, at least one of which years shall be diversified. A year is defined as not less than 11 calendar months.

Proposed solutions from GAO Report • The GAO report includes several alternative solutions. One calls for the creation of a new and more comprehensive examination that would more fairly evaluate foreign medical graduates than the ECFMG now does. The National Board of Medical Examiners is presently preparing the Comprehensive Qualifying Examination, the CQE, which could be given to all medical graduates, both of U.S. and foreign schools. The Federation of State Medical Boards is planning a FLEX I and FLEX II series of examinations; with FLEX I for all medical school graduates as a requirement for entrance into all postgraduate medical education. The CQE could serve as the FLEX I. FLEX II would be a comprehensive clinical examination given to all physicians after postgraduate training as a uniform method of granting medical licensure in all states. The FLEX I-CQE concept would prevent ill-prepared medical school graduates, U.S. or foreign educated, from direct access to patient care required during postgraduate training.

The second GAO proposal would require the inspection and accreditation of all foreign medical

schools, utilizing the concepts which are presently used by the LCME to accredit all U.S. and Canadian medical schools. Only graduates of accredited medical schools would be entitled to enter postgraduate educational programs, clinical clerkships, or to obtain medical licensure. U.S. citizens would be discouraged from attending foreign medical schools, that were unwilling to comply or who had failed the accreditation process, by the prospect of not being eligible for licensure.

The GAO report points out the international political implications that could arise from the prospects of having a U.S. governmental or private agency making demands for on site inspection of schools on foreign soil. The large number of schools in the world, over 1,150 WHO listed schools, would make the process difficult and costly and many schools, especially those with few or no U.S. citizens, would refuse to cooperate.

Most U.S. citizen foreign medical students try to obtain undergraduate clinical education at U.S. hospitals and the type, length, and extent of that training was not comparable to the training provided to U.S. medical students.

The third GAO proposal calls for the creation of a special accrediting body, either private or under the direction of the U.S. Department of Health and Human Services, which could determine whether foreign medical graduates are properly prepared to enter graduate medical education and obtain medical licensure in the United States. The body could establish uniform standards, determine length and scope of additional training, if required, and designate specific U.S. hospitals as centers for training. All foreign medical graduates would require action by the body in order to receive education or licensure in the U.S. All postgraduate education would be provided to the foreign medical graduates at their own expense. The AMA concurs with the proposal for an independent accrediting body but believes that it should be formed in the private sector without federal involvement of any kind.

Conclusions and discussion • The medical education and licensing process in the United States has, without plan or malice, discriminated against U.S. citizens who have chosen the First Pathway toward medical licensure: education at a U.S. or Canadian medical school. These schools are scrupulously inspected and accredited and students are

selected with great skill and care. Students at U.S. and Canadian medical schools are generally the finest medical students that can be found anywhere, studying at generally the best group of national medical schools in the world. These students must then go on to pass all three parts of the National Medical Board licensing examination in order to obtain a valid medical license.

The examinations presently provided to foreign medical graduates as a means to obtain medical licensure may not be fully adequate measures of the physicians knowledge of medicine and ability to take care of patients in the United States.

Foreign medical school graduates, on the other hand, who now number close to 100,000 persons in the U.S., or 25% of all physicians, have come from medical schools of varying and uncertain quality. The examinations presently provided to foreign medical graduates as a means to obtain medical licensure may not be fully adequate measures of the physician's knowledge of medicine and ability to take care of patients in the United States. The licensing process has been particularly vulnerable to U.S. citizen graduates of foreign medical schools whose knowledge of English and ability to prepare for and pass certain examinations allows them easier access to medical licensure in the U.S. than foreign nationals who have attended the same schools.

The actions by New York state are important, but it will be extremely difficult for all states, especially smaller and less wealthy ones, to fulfill such goals independently. Each state cannot be expected to inspect all medical schools on foreign soil that have one or more graduates who seek licensure in their

state. A unified action must be taken as proposed by the General Accounting Office report so that all states can share both the burden and the benefits of such an endeavor. The private sector should assume a leadership role, as is being planned by the Federation of State Medical Boards, so that the federal government does not have to become involved.

The efforts of this report and of all those involved in medical education and licensure in the United States should not be construed by anyone to represent a bias against all foreign medical schools because they are foreign, or employ an alternate method of medical education. There are many fine established medical schools all over the world that graduate fine physicians. Teachers and scholars at these schools have made significant contributions to medical knowledge for the entire world. The purpose of this paper and other diverse efforts is to assure equity in the selection of U.S. citizens for entry into the medical profession, and to guarantee the continuation of only high quality medical care to the citizens of our nation.

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NOTES & NEWS

Dr. Alexander D. Brickler named "Family Doctor of the Year"

Alexander D. Brickler, M.D. of Tallahassee has been named 1982 *Good Housekeeping* "Family Doctor of the Year". The announcement of this award was made by Dr. C. Everett Koop, Surgeon General of the United States, in a ceremony held on September 9, 1982 in Washington, D.C.

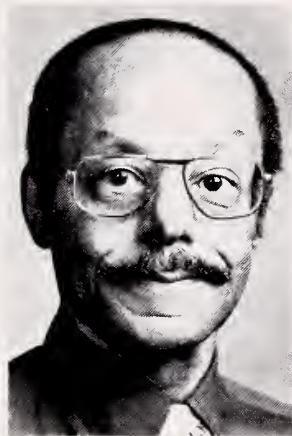
Selected from among ten finalists representing American Academy of Family Physicians Chapters throughout the nation, Dr. Brickler had been named "1982 Florida Family Physician" at the Florida Academy of Family Physicians' 33rd Annual Scientific Assembly in June of this year.

Dr. Brickler is a graduate of Howard University, Meharry Medical College and did his internship at Lockbourne Air Force Base Hospital.

He is a diplomate of the American Board of Family Practice, a fellow of the AAFP, and a member of AMA and FMA. Dr. Brickler served as President of the Capital Medical Society in 1981.

Associate Director of the Family Practice residency program of Tallahassee Memorial Regional Medical Center, he has also served as chairman of the executive committee of that hospital and as director of the Student Health Center and chairman of the medical staff of Florida A & M University Hospital in Tallahassee.

Dr. Brickler and his wife, Dorothy, have four children.



Dr. Brickler

PLI UPDATE

Hospital liability for independent contractor

A Florida Appellate Court has recently rendered a decision dealing with the question of whether a hospital can be held liable for alleged negligent diagnosis and treatment of an emergency room physician. Specifically, the issue to be decided by the jury in this case was whether an emergency room physician was an employee of the hospital, thus making the hospital vicariously liable for his negligence, or an independent contractor for whom the hospital could not be held accountable.

Evidence was produced at trial to show that the physician operated as a professional association. He worked only in the emergency room of the hospital, for 48 to 50 hours per week. He had no patients of his own, kept no records and sent no bills. He performed no follow-up care on hospital patients he treated unless they had no regular physician. He was required to see all patients who came to the emergency room. The hospital furnished all support personnel for the emergency room, provided all supplies and medicine, managed the billing and receipts, and paid the physician an hourly rate for his services. The hospital withheld no income tax or social security on payments to him. The hospital's emergency department had a policy and procedures manual and the medical and dental staff of the hospital had by-laws that controlled the emergency room. These by-laws contained detailed instructions on the manner in which emergency room care was to be administered, including mandatory procedures to be followed in specific situations. There was no sign in the emergency room or any other thing that would put a person on notice that the emergency room doctor was not an employee of the hospital. Further, the patient testified when she went to the emergency room, she thought the emergency room doctor was a hospital employee.

Independent contractor • The hospital contended that the emergency room physician was an independent contractor rather than an employee, and as a consequence, it was not liable for his alleged negligence. Accordingly, the trial court instructed the jury that an employer could be held vicariously liable for the negligence of an employee or agent committed within the scope of this employment. The jury was further advised that an employer is not responsible for such negligence if the person employed is an independent contractor. The case against the hospital was tried by jury and resulted in a finding

of no liability because the jury felt that the emergency room physician was not an employee of the hospital.

On appeal, the patient argued that the trial court had committed error in failing to instruct the jury that there were exceptions to the independent contractor rule. In particular, the patient argued that, although she felt the emergency room doctor was an employee of the hospital, even if he was an independent contractor the hospital remained liable under several exceptions to the independent contractor rule.

The first exception, known as the doctrine of apparent authority, provides that in those cases where it can be shown that a hospital, by its actions, has held out a particular physician as its agent and/or employee and that a patient has accepted treatment from that physician in the reasonable belief that it is being rendered in behalf of the hospital, then the hospital will be liable for the physician's negligence. The second exception to the independent contractor rule provides that one may not escape his contractual liability by delegating performance under a contract to an independent contractor. The contracting party remains liable for the negligent performance of the contract whether it be performed for him by his employee or an independent contractor. Under this exception, even if the emergency room physician was an independent contractor, a jury could still find that the hospital would nevertheless be responsible for his negligence.

In the present case, the patient came to the emergency room of the hospital for treatment. As far as she was concerned, all of the personnel furnished in the emergency room were hospital employees. The hospital held itself out as affording emergency treatment and was under a duty to do so properly. Under the circumstances, the Court felt that it was erroneous not to instruct the jury regarding these exceptions and, therefore, reversed the judgement and remanded the case for a new trial.

Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel, and Anthony J. McNicholas III, J.D., Associate Legal Counsel, Professional Insurance Management Co. (PIMCO), Jacksonville, Florida.



DEAN'S MESSAGE

Who's in charge?

The phrase "care of the sick" has been synonymous with medical care and all its ramifications. "Medical costs" to the lay public means physician fees. However, only a small fraction of true medical costs are attributed to physician fees.

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As the science of medicine has progressed over the past few decades, increasing demands have been placed on hospitals to furnish high technology care. This has required huge cash expenditures for new equipment and salaries for additional personnel. Over 50% of hospital costs are for personnel. Inflation has been an enormous factor as well.

Allied health areas • Subspecialization has occurred not only in the medical profession, but in the allied health areas as well, escalating costs even more. The demand for baccalaureate and masters educated nurses has soared. Pharmacists are receiving a Doctor of Pharmacy degree as the professional degree *in lieu* of the Bachelor of Pharmacy. Physician assistants' programs have been developed. The accrediting agency for allied health programs, Committee on Allied Health Education and Accreditation, currently reviews 26 different allied health educational programs. Many have begun within the past 20 years.

With an increasing number of people in a high variety of disciplines receiving a "professional education," increased costs follow.

These health care workers want to be perceived as professionals. In tandem with this desire is a growing desire to practice their profession more and more independently — to be an equal partner with the physician in care of the sick — not a member of a team with the physician as captain.

We, as physicians, must retain the practice of managing all health care. Simply put, it's best for the patient. With increased pressure to contain costs and decreasing resources for reimbursement, physicians must be assertive in providing the leadership in patient care.

*William B. Deal, M.D.
Dean, College of Medicine
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University of Florida*



WORTH REPEATING

The playground: a lucrative workplace

Editor's note: Dr. DeBakey, Professor of Scientific Communication at Baylor University, was the speaker at the 1982 combined meeting of the Committee on Scientific Publications and the Board of Consulting Editors in March.

The skyrocketing salaries of professional athletes do not seem to bother fans, even in economically depressed times. And so long as fans will plunk down ever more of their hard-earned cash to watch these performers play their games, the salaries will continue to soar.

In the consumers' hands lies the ultimate defense: their refusal to pay escalating prices for sports tickets or for the products sold by sponsors of games broadcast. That will not happen, of course, until we reorder our values and adjust our attitudes. The constant beefing about the "high cost of health care," for example, is puzzling in light of our mute acquiescence in the high cost of entertainment. Is entertainment more vital than health? The fan who willingly shells out \$50 to watch a ball game will grumble loud and long about a \$50 fee for medical care. Yet the average annual income of physicians is only about \$70,000, whereas the average annual salary of major league baseball players is a preposterous \$250,000 — quite a jump from the \$52,000 of six years ago. Who do you think pays for the increases? Do the owners absorb them? Of course not; the extra costs, as always, are passed on to the consumer.

How many fans have quintupled their salaries in a brief six years? How many, like rookie Fernando Valenzuela, receive a salary of \$350,000 in their second year of service? True, he got considerably less than the \$1 million he was demanding, but an 824 percent increase isn't to be sneezed at. Boxer "El Torito" Ayala puts the matter in perspective: "Other 19-year-olds are thinking about getting a job and I'm thinking about buying a house that costs \$300,000."

But we've been discussing ditchdiggers' salaries, to use George White's apt phrase. What about Dave Winfield, Pete Rose, Kareem Abdul-Jabbar, and Bjorn Borg, who collect a million or more a year? Nor is it even necessary to give the fans their money's worth. Roberto Duran received a reported \$8 million after throwing in the towel in the eighth round of a boxing match. Can you imagine what would happen to a surgeon who took similar action in the middle of a difficult operation? He'd be slapped with a whale of a malpractice suit, that's what.

Reggie Jackson's words earlier this year were most revealing. "Once [the] season starts," he said, "I'm six months away from the Brinks Job. Please go past 'Go' and collect \$9 million from somebody." Was the imagery of a "big heist" a Freudian slip, or was it sheer arrogance? Today pro athletes play musical teams, selling themselves to the highest bidder, and even try to renegotiate valid contracts. And they call doctors greedy?

Do these pros invest more time and money than physicians in education and training? Does their work require longer hours or more intelligence, skill, or patience than medical practice? Is their performance more socially beneficial? Do they have a higher overhead, worse headaches with office management and government regulations, or larger malpractice insurance premiums? The questions deserve serious reflection.

Let's compare athletes' salaries with those in still other occupations. The median income of professional

writers is less than \$5,000 a year! Poor Dave Winfield, he lost more than one and a half times that much daily — \$7,777 — during last year's baseball strike. No wonder he resented the sportswriters having "made all the hoopla about our salaries." The complaints are conspicuously absent, however, so long as sports reporters provide the superstars with free, favorable publicity, recording their words before, after, and between games — no matter how fatuous, grammatically fractured, or heavily punctuated with "you knows" and "I means." Don't these reporters, some of whom are among our most talented journalists, deserve a gold medal for listening to such inanities day in and day out without flinching?

Are these widely quoted athletes' contributions to society more durable and substantive than those of writers who record contemporary events and mores for future historians? Or is it that we penalize those who choose careers of the intellect? Is brawn more precious than brain? If not, why do we glorify and pay 7-figure salaries to some entertainers who can barely articulate while we demean and severely underpay teachers, to whom we entrust our children's education? Is the challenge on the playing field greater than that faced by teachers of reading, writing, and reasoning in a crowded classroom of undisciplined, uninterested, and sometimes unfriendly children? Do writers and teachers — or athletes — require more patience, compassion, and intelligence in performing their duties? Granted, the stereotype of the dumb athlete may be unfair, but how many really cerebral superstars do you know? No less a sage than Billy Martin is quoted as saying: "I don't allow any of my players to do anything that doesn't come from a sign. For the players who can't get signs — and you do have players like that, dumb players — I have dumb signs for them."

Are the athletes' contributions more momentous than those of the President of the United States? His annual salary is only \$200,000, and we don't give him six months off each year. You say it isn't fair to compare salaries in the public and private sectors? All right, then, let's compare the million-dollar contracts of athletes with the salary of the Chairman of the Board of a major metropolitan bank — \$345,000 a year. Or with that of the Chief Executive Officer of a metropolitan utility firm — \$183,275 a year. The point is, are we rewarding people, regardless of the source of their remuneration, according to their true worth? Free enterprise is a keystone of our society, but does that mean that we, as consumers, cannot exercise fairness in the comparative values we place on individual performance or that we cannot practice good sense in establishing upper limits on what we will pay for products?

As for the argument that the brevity of an athletic career justifies the jumbo salaries, where in the open market is it decreed that risks of occupational stress, injury, and death must be overcompensated with million-dollar contracts? Life, after all, is uncertain,

and when the rest of us fall victim to a catastrophe, even in the line of duty, we must simply make the necessary adjustments, including financial sacrifices. Are athletes somehow supposed to be shielded from life's vicissitudes? Furthermore, with the capital they will have amassed from their salaries, endorsements, personal appearances, and perks, they should have little difficulty moving from their cushy jobs on the playground to the conventional workplace. By then their names alone, thanks in large part to sports reporters, will be worth a bundle.

Unless they squander their incomes, professional athletes can continue, after retirement, to live in the affluent style to which their fans allowed them to become accustomed. While the average fan is struggling to meet his rent and utility bills, most ex-pros are living high on the hog — plush mansions, luxury cars and yachts, first-class travel, and loads of tax shelters. O.J. Simpson bagged a million-dollar contract as a huskster for Hertz Rent-a-Car, and Broadway Joe Namath got a similar deal from Faberge. Can they attribute those fat contracts to their athletic prowess? Hardly. The credit goes to their hard-nosed agents, their enterprising publicists — and the unsung and modestly paid sports reporters who made these athletes' names household words.

Not only professional athletics, but college sports, too, have been tainted by filthy lucre. Money, not self-discipline, fair play, or physical fitness, is the name of the game today. Amateur sports is an obvious misnomer. In universities, where the primary business is presumably education, the average annual salary of coaches is \$150,000 to \$200,000, as against \$32,000 for professors. And why not, when alumni will contribute toward a winning team what they will not contribute toward better education? Since the man who pays the piper calls the tune, the care-and-feeding of alumni receives high priority. At one university, 48 private boxes at \$50,000 each (exclusive of season tickets) were sold out in one day. Booster clubs lure young athletes with enticements of money, cars, apartments, stereos, designer clothes, airline tickets, abortions for girlfriends, and other irresistible bait. Are any class valedictorians similarly courted? Such unethical practices, coupled with unearned college credits and forged transcripts, have created a national scandal of major proportion.

A district judge, ruling that a college athlete cannot be removed from a team simply because of "inappropriate grades," explained his decision thus: "The plaintiff was recruited to come to the University of Minnesota to be a basketball player and not a scholar. His academic record reflects that he has lived up to those expectations." But has the college lived up to that student's reasonable expectation of a college education? Now comes the specter of the college athlete's union, demanding tutoring, tuition-free courses for as long as necessary to complete degree requirements, revenue-sharing, and other benefits

for these college "employees." University officials may now be forced to acknowledge that professional athletics is a major function of educational institutions.

In addition to encouraging dishonesty and greed, the commercialization of sports has aroused vicious feelings and savage behavior. We wink at the illegal tactics used to win games — use of drugs, helmet spearing, spitballs, and other deceptive practices. We profess to believe in non-violence, but we seem to relish and reward the "killer instinct" because, after all, "nice guys finish last." One linebacker, known as "The Assassin," bragged about the "knock-outs" and "limp-offs" he caused. Quite a model for our youngsters to emulate. Big-money sports excite such deep passions that violence extends into the stands, where fan(atic)s, with murder in their hearts, have hurled Frisbees, bottles, and other dangerous missiles at players — and have even threatened their lives. According to Dave Parker, one target of spectators' wrath, "Baseball fans are getting ignorant all around the world."

Because superstars are today's heroes, their public behavior strongly influences our youth. But the lifestyles of some leave much to be desired. The hawking of chewing tobacco and snuff by some star athletes (for a sizable fee) has made these practices a rage among high school and college youths — to the detriment of their health. As highly visible public figures, professional athletes also have an obligation to their colleagues and the public to maintain acceptable standards of behavior, even though their adoring fans generously forgive their transgressions. So deep does the superstardom cult run, in fact, that Dan Aykroyd would unabashedly rationalize John Belushi's fast-track, drug-dominated lifestyle with this poppycock: "Real greatness gives real license for great indulgence. There had to be illicit thrill to make it all worthwhile." What an insult to our intelligence!

To enhance their public images — at no cost — the pros, along with other entertainers, have lately invaded the health field. While doctors are called uncaring, who is it that exhorts us to live the good life? The superstars, of course. No matter if they abuse their own health. No matter if they lack medical credentials; we endow our superstars with omniscience. Mean Joe Greene, speaking for the Arthritis Foundation, says "We're working hard to find new, effective treatments and cures." We??? Reggie Jackson is fighting amyotrophic lateral sclerosis; Billie Jean King, multiple sclerosis; Sugar Ray Leonard, kidney disease; and Robert Newhouse, hypertension. But then that makes as much sense as Pete Rose peddling Britannica III. Of course, if the public considers Brooke Shields to be a credible mouthpiece for the American Lung Association, and if Loni Anderson can persuade listeners that she knows what she's talking about when she holds forth about amblyopia, I've got this bridge in Brooklyn I'd like to sell those gulls.

While flesh-and-blood physicians catch all

the flak about the "high cost of health care," who scoops up the millions for "playing doctor"? The superstars, of course. Jack Klugman and Alan Alda receive more money for one television segment than the average physician makes in a year! Does anyone call them greedy? While real doctors are pilloried, Quincy and Hawkeye — those creative, charismatic, compassionate celluloid characters — are loved and lionized. Well, the next time you get sick, consult Hawkeye. He'll charge you just what his medical advice is worth — nothing.

Do we honestly expect to motivate young people to take school seriously when society reserves its highest monetary and social rewards for occupations in which education is not paramount and is often even unnecessary? We name streets and buildings for our superstar entertainers; we lavish money, awards, and adulation on them; and we forgive them their trespasses as ours are rarely forgiven. We make them official heroes, pay thousands of dollars for their discarded possessions, and fawn obsequiously over them — in short, we deify them. One highly paid college coach, when asked if he didn't see something fundamentally absurd about his receiving a salary severalfold that of a Nobelist-professor, replied "I didn't create those values, and you're not going to change them." No, we're not going to change them — unless we pause, take stock, and begin to think about what is best for our society. Only then will we stop the profit-hungry pleasure-peddlers from trying to brainwash us into thinking that "having fun" supercedes all else in life and that the performers they have carefully packaged, promoted, and sold us are worth the money they receive. To those who argue, "But that's what the public wants," I reply that an alcoholic hospitalized for cirrhosis of the liver may want a drink, but is obliging him in his best interest? Or do we have a nobler human purpose?

The thrill and beauty in a champion athlete's physical dexterity cannot be gainsaid, and all who reach for excellence in any endeavor should be adequately rewarded, but the question is whether an obsession with entertainment, and its overcommercialization, should override health, education, and the highest human values. Recreation is important, but is it life's primary goal? Is it the be-all and the end-all of living? Our fate as a nation depends not on transient fads in folk heroes or mass entertainment, but on how effectively we use those two qualities that separate man from lower animals — reason and language. It is primarily through those two assets that we will overcome war, poverty, crime, injustice, repression, disease, and the other evils that plague us. Let's put those assets to work.

*Lois DeBakey, Ph.D.
Houston, Texas*

Reprinted with permission from the Houston Chronicle, April 26, 1982.

Membership — had this been an actual emergency...

An image is a mental impression "held in common by members of a group and symbolic of a basic attitude."

Organized medicine realizes to what extent images, particularly false ones, can be damaging. "Organized medicine does nothing for me, so why should I do something for it." The doctor with this attitude perpetuates an image that is, at best, a hard sell to undo.

For those of us willing to put ourselves on the line, shove our complaints directly in front of the lawmakers, roll up our collective shirtsleeves and channel our efforts toward constructive change, it becomes far easier to work within a system that works for us, than to fight it, and have it work against us. For those who shun responsibility, problems become manifest. It is not the intent of organized medicine to candycoat problems, but to solve them.

There's a symbolic relationship that exists between federated medicine and its members — we need each other. An association is only as effective as the support given to it by its membership, and the membership is only as effective as its united voice.

The AMA Council on Long Range Planning Development has observed that organized medicine "cannot continue to pursue an aggressive program to represent the profession, pursue scientific excellence and participate in assuring high quality medical education with a decreasing share of the physician population footing the bill."

If doctors are to shape the destiny of American medicine, then doctors need to pull together. Belonging to organized medicine affords the physician benefits that provide for collective clout; active representation before the government, the press and the public; an influential voice in government, and assurance that the profession will continue to thrive.

The DCMA would like every practicing physician in Dade County to join its ranks and to express their bellyaches directly to our leadership, not to colleagues in hospital lounges and conference rooms — but up front, where it counts. The association considers membership recruitment and retention as crucial to its strength in blending the viewpoints of its physicians into concerted and effective action.

The experiences of county and state societies throughout the U.S. prove that physician-to-physician contact is the best approach to membership. William Hilliard, Executive Director of the North Carolina Medical Society, believes that "letters do good, but they will not do it all. The only really effective method is doctor-to-doctor contact and a more personal invitation to membership."

If our goals have any chance at all of succeeding, then we'd best heed that advice and make sure that our ranks are fortified.

It's been reported that there are 178,000 physicians who do not belong to local, state or national branches of organized medicine, and that the AMA now has 18,000 fewer members than it had in 1975. While the DCMA can claim a large percentage of the physicians in Dade County as association members, the impact of that general feeling of indifference toward organized medicine can be felt in our own backyard. As a group, physicians trail chiropractors and optometrists in the amounts contributed to political warchests, and in their overall participation in legislative activities.

Perhaps, it is image, perhaps it is apathy, and perhaps both. When our forces dwindle, taking along with them our ability to function effectively, the reason is almost incidental. What's important is that a loss in membership also means a sacrifice in the financial benefits that would accrue from added revenue to improve and expand existing services. What's important is that it takes unity, money and dedication to win the many battles currently inside the medical arena: insurance, HMOs, optometrists, chiropractors, malpractice, drug abuse, over-utilization, excessive fees, the cost of health care, ad infinitum. The DCMA, through its officers, committees and staff, is aggressively at work on all these issues, but without everyone's support, the climb will only be uphill.

Those who have allowed themselves to become disenfranchised from the mainstream of organized medicine, are missing an opportunity to generate new ideas where they can be heard, jump on common bandwagons and encourage new members into the fold. Those who expect the DCMA to "do everything" should also expect to provide the financial and emotional ties so necessary to the association's progress.

At present, the DCMA is providing a number of tangible services and benefits that are available to all members on a daily basis. They range from mediating complaints, settling disputes with insurance companies and providing watchdog services on legislative activities, to disseminating topical information, maintaining a referral service, investigating key issues such as professional liability, and actively participating in FMA and AMA matters.

It is hoped that as our membership grows, so will the scope of our services. To a very great extent, this will depend upon those who believe in the sanctity of unification and are willing to contribute to it. When a situation arises that affects the practice of medicine, none of us can afford to sit back and muse that "had it been an actual emergency," we would have been there. The time to be there is now, when our footing is solid.

So long as we recognize that both the burdens and benefits common to all members of the profession must be distributed and carried equally, can we begin to make lasting inroads. Whenever you encounter a colleague who has not yet made the commitment to join the ranks of organized medicine, open the door and invite him in. Explain to him the advantages of a movement that is growing and prospering, that will attend to his needs, and that will protect his right to freely practice quality medicine. Make sure he understands that the DCMA was formed nearly 80 years ago by a conscientious group of physicians who, even in those early years, recognized the need for solidarity.

Membership is the very heart of this association and it needs the nurturing of every member to keep it a healthy and vital component of organized medicine.

Robert Boyett, M.D.
Miami

Reprinted from *Miami Medicine*, January 1982.

Set the example

Along with modern realizations that disease prevention is more efficacious than disease treatment comes the realization that the preventative for most diseases is unknown. Perhaps the most healthful thing most people can do with their lives is to exercise discretion about what they eat and breathe. Tobacco, alcohol, and calories seem to play central roles in many of the chronic diseases we see daily.

Self abuse is usually not so much an indication of individual ignorance as of a lack of personal commitment to good health. For reasons that perhaps can be explained by the psychiatrists our society has raised the concept of self abuse for relief of stress to an art form. Whatever the explanation many of the traditional escapes from stress and tension involve unhealthy behavior.

A personal commitment to good health can serve as an incentive to finding healthful approaches to rest and relaxation. While much remains to be learned about the risks and benefits of certain types of behavior, it seems clear that for many people the ability to rationalize unhealthy behavior is related to a lack of interest in controlling their own health.

While we can't offer people the assurance that they will remain healthy if they make the effort, we must make it apparent that medicine can't reverse the consequences of years of self abuse.

Physicians have a responsibility to make their lives models of commitment to good health. When our actions say to our patients that we believe health protection is important, then it will be easier to sell them on some of the things they need to do to maintain their own health.

It has been suggested that one of the reasons for the decline in the incidence of cardiovascular death rates has been that we have made the public aware of the importance of dietary restraint, and tobacco abandonment. And at least part of that educational effort has come not from Madison Avenue, but from a change in physicians' lifestyles and public image.

Perhaps the most important thing we can do in terms of preventative medicine is to set a good example.

*Peter M. Sidell, M.D.
Fort Myers*

Reprinted from the *Bulletin* of the Lee County Medical Society, February 1982.

would cost \$35,000,000 per year. If optometric services to the aged are covered, the expense to the Social Security system would be astronomical.

As physicians we have a responsibility to present the truth to our legislators.

*Waite S. Kirkconnell, M.D.
Tampa*



CORRESPONDENCE

On optometrists and medicare

To the Editor: Medicine should be aware of proposed changes in the Medicare law, which is being very actively lobbied by organized optometry. These changes would drastically alter the way that a physician is paid by Medicare Part B, and could lead to the bankruptcy of the Social Security system. These proposed changes have been euphemistically named Medicare Phase II. The AOA proposal originally presented to Health Care Finance Administration in May 1981 calls for mandatory acceptance of assignability for all providers of ambulatory eye/vision services under Medicare; reimbursement to optometrists for all services covered under Medicare which they are licensed to perform and elimination of the exclusion for refraction services.

The optometrists claim that this proposal would save \$3,000,000 in eye/vision care costs to the elderly the first full year of implementation alone. Harold Demmer, O.D., president of American Optometric Association, calls this proposal "...rare solution to a serious health care problem...addresses the situation...its implementation will actually reduce overall cost while improving and expanding coverage". Dr. Demmer has pledged that the enactment of Medicare Phase II will be the major goal of all federal optometric political activity!

We must take this program seriously. The optometrists were in Washington on May 4, 1982 and contacted every member of Congress, and asked their support for this program. The optometrists are superb lobbyists and always present an excellent impression on legislators. The American Academy of Ophthalmology sponsored a study by the Orkland Corporation which shows that extending Medicare coverage to include all optometric services to aphakic patients



ETC.

AMA English pronunciation seminar in Miami

The American Medical Association will conduct an English Pronunciation Seminar for foreign medical graduates in Miami next month.

The one-day session, to be held at the Marriott Hotel, 1201 N.W. LeJeune Road, will be held on November 6 from 9:00 a.m. to 5:00 p.m. Eight hours of AMA Category I Credit will be offered.

According to the AMA, participants will: improve spoken communication with patients and colleagues; hear a lecture and participate in an intensive oral drill; practice sounds of American English; receive individual instruction through discourse and extemporaneous reading; and receive tapes and textbook for 30 hours of home study. Fees, including tuition and textbook and cassettes, range from \$156 for AMA members to \$204 for nonmembers, with reduced rates for residents.

Additional information may be obtained by contacting: Mr. Gale K. Jewett, Department of Medical Informatics and Physician Qualification, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610, telephone (312) 751-6570.

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussions of medical history and ethics; and articles dealing with socioeconomic, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to Daniel B. Nunn, M.D., Editor of *The Journal*, Florida Medical Association, Post Office Box 2411, Jacksonville, Florida 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

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List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given.

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Aside from enabling patients to fall asleep more quickly and sleep longer, Dalmane seldom causes morning hangover. Most Dalmane patients feel alert and refreshed when they awaken. In 53 paired-night clinical studies comparing Dalmane and placebo in 2010 insomniac patients with a variety of secondary diagnoses, most Dalmane patients awakened more alert and refreshed, and less groggy and drowsy, than on nights when they had taken only placebo.¹ In a double-blind crossover study of

42 patients in private practice, approximately three times as many patients reported feeling refreshed and alert upon awakening after a night on Dalmane (flurazepam/Roche) compared to placebo nights.² This difference was highly significant ($p < 0.001$). And a retrospective study of 2542 hospitalized patients who received Dalmane revealed only a 3.1% incidence of side effects.³

While residual effects from Dalmane therapy are infrequent, patients should be cautioned about drinking alcohol, driving or operating hazardous machinery after ingesting the drug.

Efficacy and safety in a broad range of patient types.

Over 2000 clinical trials involving more than 10,000 patients have shown that Dalmane patients fall asleep sooner, sleep longer and experience fewer nocturnal awakenings.⁴ The safety and efficacy of Dalmane have been demonstrated in medical and surgical hospitalized patients, in patients seen in office practice and in elderly patients.⁵⁻⁸ Since the risk of oversedation, dizziness, confu-



sion and/or ataxia increases with larger doses in the elderly, it is recommended that the dosage be limited to 15 mg.

Moreover, the efficacy and safety of Dalmane for the treatment of insomnia have been demonstrated in thousands of patients with a variety of primary medical conditions, including cardiovascular, neuropsychiatric, endocrine-metabolic, gastrointestinal, genitourinary, respiratory and musculoskeletal disorders.¹ Dalmane (flurazepam HCl/Roche) is contraindicated in pregnancy and in patients hypersensitive to the drug.

Avoids rebound insomnia upon discontinuation.

Rebound insomnia—a worsening of sleep beyond pretherapy levels after drug discontinuation—has been reported as a potential clinical problem with some hypnotics.^{9,10} However, this problem has not been reported with Dalmane. In eight out of eight sleep laboratory studies, there were no reports of rebound insomnia.¹¹ When you prescribe Dalmane, you can be confident of efficacy that enhances therapeutic progress. Your insomniac patients can be assured of a restful night, night after night—a good start for a good morning.

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

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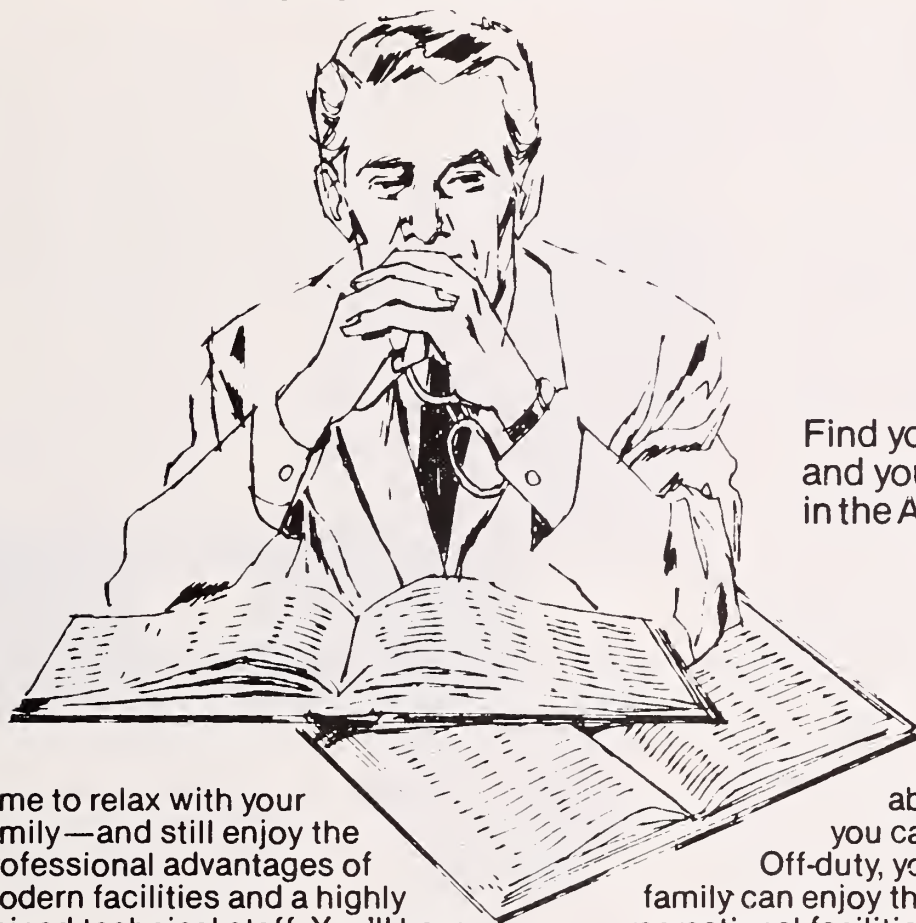
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Book Review Editor — **F. Norman Vickers, M.D.**

Woodrow Wilson: A Medical and Psychological Biography

By Edwin A. Weinstein, M.D., 399 Pages, Price \$18.50. Princeton University Press, New Jersey, 1981.

Dr. Edwin A. Weinstein, a professor of Neurology, Emeritus at Mount Sinai and Fellow of the White Institute of Psychoanalysis in New York, writes about Woodrow Wilson from an unusual and different perspective — that of an historian and physician. This book attempts to combine the two perspectives into a logical narrative and accomplishes the task interestingly and at times rather brilliantly.

Woodrow Wilson's lifetime covers a span of interesting periods as a student at Princeton and the Law School of the University of Virginia, as professor at Bryn Mawr and Wesleyan University, as president of Princeton University in 1902, as Governor of New Jersey in 1910 and as President of the United States beginning in 1913 during the time of the First World War.

Wilson coped, in his private and public life, with many stresses. In addition to the pressures of ascending the ladder of politics in a university and as a politician in state and national government, he also dealt with the pressures of love including two marriages and an extramarital relationship, and the pressures of war, revolution and peace making.

During his life he also suffered from a variety of psychological, neurological and medical illnesses. These included dyslexia as a child, multiple stress related psychosomatic complaints, severe depressions, and progressive cerebro-vascular disease associated with multiple transient ischemic attacks and strokes. He experienced his first stroke at age 39 in 1896 when he was a Princeton professor; ten years later in 1906, when president at Princeton, he had a vascular occlusion of the left eye. Minor transient ischemic episodes involving the right side occurred during his terms of Governor of New Jersey and as President of the United States and in April 1919, he developed a probable severe viral influenza followed in October 1919, by a massive left-sided hemiparesis with significant mental changes.

This volume deals with Wilson's health and personality and considers the impact of his illnesses

on his University tenure and later on state, national and international events.

Dr. Weinstein begins his book by a review of his family and Scottish-Presbyterian religious background (his father was a minister), and continues with the growth of his personality during his early years. Wilson's dyslexia is considered in terms of its effects on his relationship with his parents and schooling and on the development of his thoughts and language. His multiple psychosomatic complaints of indigestion, frequent colds and headaches and his depressive episodes are evaluated from the standpoint of stresses involved with his parental expectations, his marital and extramarital relationships and his relationship with friends and enemies. Weinstein interprets Wilson's writings and political speeches and statements as, at least in part, symbolic representations of his illnesses and personal problems. It is almost impossible to separate causes from effects in the sequence of Wilson's emotional disturbances since the elements are interwoven and reinforcing.

A unique attribute of Wilson's personality is also considered, especially his modes of adapting to stress and his ability to reconceptualize reality in new cognitive and symbolic patterns. Throughout his career, themes which in one context were catastrophic to him became positive achievements in another. For example, he adapted to his reading difficulties by learning shorthand and formulated and wrote on a theory of history which dispensed with accumulation of detailed facts. He countered his failure as a practicing lawyer by a brilliant concept of the teaching of law. He used concepts in language which contributed to disappointments and defeats while president of Princeton, but launched into a successful career in politics. He used ideas to relieve him of the sin of having an extramarital love affair to develop a new concept of New Morality in politics — that of individual responsibility. The symbols of humanity and justice were used initially as propounding neutrality and peace prior to the First World War and later became the moral justification for America's entry into the war.

The book is published as a supplemental

volume to the The Papers of Woodrow Wilson. Dr. Weinstein is the first to use the extensive correspondence in a psychological study and as such offers a new insight into a complex man and his time.

The book is highly recommended to physicians and others interested in history and especially to those who wish to study the shaping of national and international events based in part on an individual's medical and psychological profiles of development.

Mark V. Barrow, M.D., Ph.D
Gainesville

● Dr. Barrow practices internal medicine and cardiology in Gainesville and has been a contributor to the historical issue of the *Journal*.

The path to pain control

By Meg Bogin, 242 Pages. Price \$12.95. Houghton Mifflin Co., Boston, 1982.

"The path to pain control is a process, a way of living with pain and learning from it over time. One's relationship to pain is constantly changing, for pain doesn't have to be something one just reacts to, it can be a catalyst that leads to pain reduction and control, a catalyst for change." Composed for people with chronic pain, this book is not a scientific treatise on the subject but a step-by-step manual for sufferers and was written by a layman incapacitated with unremitting pain who, with the help of physicians, pharmacologists, friends and others in similar anguish, was able to overcome her torment and write a book on how one's misery might be modulated. Not written for doctors, there are three reasons for reviewing it in a medical journal: (1) It is an excellent book to recommend to a patient with such agony. (2) The chapter "Dealing with Doctors" should be required reading for anyone graduating from medical school. (3) One sentence from that chapter, advising those with unceasing pain, should be imprinted on every resident's specialty certificate: "If you feel talked down to, slighted, made fun of, humored, over medicated or intimidated, you are dealing with the wrong person. Change doctors."

C.M.C.

A land beyond tears

By Barry Neil Kaufman and Suzi Lyte Kaufman. 216 pages. Price \$13.95. Doubleday and Company, Inc., New York, 1982.

This short book is a gentle, heartwarming story of 17-year-old Sam Millen, who encounters

falsehoods and painful silence as he slowly realizes his mother's illness is a disease from which she cannot recover.

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A book every doctor should read, it would be an invaluable gift to any member of a family of a terminally ill patient.

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Legislation: IT'S up to you

This year the theme of the AMA Auxiliary's Legislation Committee is "IT'S up to you." The key word in the theme is IT'S — involvement tips the scales. You are the ones who can make legislation action a reality, and action brings results.

A crucial test of the government's powers over the learned professions, including medicine, is building on the local, state and national level. The outcome of the legislative struggle could have a lasting impact on the practice of medicine. This presents a case in which you can not delegate; you must get involved.

With significant changes in our state's district boundaries and the shift to single member districts as a result of reapportionment, it has been predicted that there will be a change in the "face" of the Florida Legislature. The question is whether these "new faces" will be interested in and respond to the problems of medicine in a favorable way. This is where we, as a medical family, need to become political activists.

FLAMPAC support • Our Florida Medical Political Action Committee is more important to us now than ever. The PAC has the ability to educate voters by providing information and guidance on the candidates and the issues. One of our priorities should be

the full support of FLAMPAC. We as responsible citizens need to act now to launch a campaign against larger government constraints.

At a time when millions of Americans fail even to vote or perform other basic civic responsibilities, we need to be stimulated to individual involvement in campaigns. Certain candidates on the local and state level are friends of medicine. These candidates need our financial support, as well as our vital involvement in their day to day campaign activities.

Now that the first primary is over, the second primary on October 5th is imminent. The General Election follows on November 2nd. Do you want to have a say in deciding your political future? To quote from Dwight Morrow, "The world is divided into people who do things and people who get the credit. Try, if you can, to belong to the first class. There's far less competition."

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NOVEMBER

Clinical Aspects of Serious Gram-Negative Bacterial Infections, Nov. 2, Santa Rosa Hospital, Milton. For information: Paul A. McLeod, M.D., Stuart St., Milton 32570, (904) 623-9787.

Practical Problems in the Management of the Hypertensive Patient, Nov. 2, Holly Cross Hospital, Ft. Lauderdale. For information: Jon Fichtelman, M.D., Holy Cross Hospital, P.O. Box 23460, Ft. Lauderdale 33307, (305) 771-8000 Ext. 5828.

Pacemaker Electrocardiography and Dual Chamber Pulse Generators, Nov. 3, Wolfson Auditorium, Mount Sinai Medical Center of Greater Miami, Miami Beach. For information: Philips Samet, M.D., (305) 674-2311.

Psychopharmacology for the Practicing Internist, Family Practitioner & Psychiatrist, Nov. 4, 5, 6, Dutch Resort Hotel, Orlando. For information: Robert Needleman, M.D. (305) 841-5144.

Clinical Management of Coronary Disease and Dual-Mode Exercise Testing, Nov. 5-7, Hilton Gateway, Orlando. For information: Stephen E. Mattingly, International Medical Education Corporation, 64 Inverness Drive E. Englewood, Colorado 80112.

Glimpses Forward — Clinical Applications of New Diagnostic Imaging and Interventional Techniques, Nov. 11-13, Wolfson Auditorium, Mount Sinai Medical Center, Miami Beach. For info.: Manuel Viamonte Jr., M.D., 4300 Alton Road, Miami Beach 33140, (305) 674-2311.

Obstetrical & Gynecological Seminar, November 12, Good Samaritan Hospital, West Palm Beach. For information: William A. Casale, M.D., 901 N. Flagler Drive, West Palm Beach 33401, (305) 659-0377.

Update Gastrointestinal Diseases, November 13, Caribbean Gulf Hotel, Clearwater. For info.: Walter W. Hamilton, M.D., Palms of Pasadena Hospital, 1501 Pasadena Avenue, St. Petersburg 33707. (813) 345-9301.

Advances in External Fixation Nov. 12-14, University of Miami School of Medicine, Miami. For information: Univ. of Miami School of Medicine, Dept. of Oncology, Box J-277, JHMH, Gainesville 32610. (904) 392-4611.

New Directions for Clinical Mandibular and Maxillary Oral Reconstruction, Nov. 13, Edward H. White II Memorial Hospital, St. Petersburg. For information: Billie Sorter, Edward H. White II Memorial Hospital, 2323 9th Avenue, N., St. Petersburg 33713, (813) 323-1111 Ext. 1331.

Medical Oncology Grand Rounds, Nov. 19-20, UF College of Medicine, Gainesville. For information: Roy S. Weiner, M.D. Chief of Medical Oncology, Box J-277, JHMH, Gainesville 32610. (904) 392-4611.

ACLS Course, Nov. 17-19, Naval Regional Medical Center, Jacksonville. For information: Frank J. Kuczler Jr., M.D., Naval Regional Medical Center, NAS Jacksonville 32214, (904) 772-2227.

Advanced Cardiac Life Support for Physicians, Nov. 18-21, Fawcett Memorial Hospital, Port Charlotte. For info.: Shirley A. Sharan, M.D., 101 NW Olean Blvd., Port Charlotte 33952, (813) 625-9163.

Maxillofacial Pain Symposium, Nov. 20 & 21, Gainesville Hilton, Gainesville. For information: Marvin M. Slott, M.D., 6510 N.W. 9th Blvd., Suite #4, Gainesville 32605, (904) 377-2016.

Infectious Disease - Infectious Hepatitis, Nov. 22, Medical Center Hospital, Largo. For information: Paty Schleyer, 201 14th Street, SW, Largo 33540, (813) 586-1411.

DECEMBER

Clinical Allergy & Immunology for the Practicing Physician, Dec. 2-4, Dutch Inn Resort Hotel, Lake Buena Vista. For information: Richard Lockey, M.D., Univ. of South Florida, College of Medicine, Division of Allergy, (813) 971-4500 Ext. 596.

Neuro-Ophthalmology Dec. 2-4, Miami. For information: Univ. of Miami School of Medicine, Dept. of Ophthalmology (D880), P.O. Box 016960, Miami 33101, (305) 547-6540.

ECG Interpretation and Arrhythmia Management, Dec. 3-5, Bahia Mar Hotel, Ft. Lauderdale. For info.: International Medical Education Corp., Division of Postgraduate Education, 64 Inverness Drive E., Englewood, Colorado 80112.

Advances in Technology for the Management of Musculoskeletal Disability, Dec. 6-8, Miami. For information: Univ. of Miami School of Medicine, Dept. of Orthopedics (D27), P.O. Box 016960, Miami 33101.

Ultrasound As Used In Modern Obstetrics and Gynecology, Dec. 8-12, Miami Beach. For information: Univ. of Miami School of Medicine, Dept. OB/GYN, P.O. Box 016960, Miami 33101.

Human Sexuality, Dec. 8-11, Disney World, Orlando. For info.: Pat Taylor, c/o Pedro Bachrach, M.D., 701 E. Semoran Blvd., #108, Altamonte Springs 32701. (305) 323-7772.

Interamerican Medical Symposium — 3rd Annual Course, Dec. 12-17, Miami Beach. For information: Dept. of Medicine (R760), P.O. Box 016960, Miami 33101.

JANUARY 1983

Medical Sociology, Jan. 6, Holy Cross Hospital, Ft. Lauderdale. For information: Jon Fichtelman, M.D., P.O. Box 23460, Fort Lauderdale 33307, (305) 771-8000 Ext. 5728.

28th Annual Cardiovascular Seminar, Jan. 7-8, Dolphin Beach Resort, St. Petersburg Beach. For information: Mr. E. Jerry Eatman, P.O. Box 7188, St. Petersburg 33734.

6th Annual Review in Oral Pathology, Jan. 10-14, University of Miami, Miami. For information: University of Miami CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

Grand Prix Road Racing — Medical Aspects, Jan. 12, Peace River Country Club, Bartow. For information: Mrs. Elsie Trask, Exec. Dir., Polk County Medical Society, (813) 682-0543.

Coexistent Pulmonary and Cardiac Disease, Jan. 12, Mount Sinai Medical Center, Miami. For information: Marvin L. Meitus, M.D. and Adam Wanner, M.D., 4300 Alton Road, Miami Beach 33140, (305) 674-2311.

2nd International Advanced Arthroscopic Update, Jan. 12-15, Sand Piper Bay, Port St. Lucie. For information: Ronald Grober, M.D., 2000 Nebraska Avenue, Ft. Pierce 33450, (305) 464-3657.

The Second Biennial Palm Beach Aesthetic Surgery Symposium, Jan. 13-16, The Breakers, West Palm Beach. For information: Douglas D. Dedo, M.D., 1515 North Flagler Drive, West Palm Beach 33401, (305) 659-2266.

8th Annual Review & Recent Practical Advances in Pathology, Jan. 17-21, University of Miami, Miami Beach. For information: Univ. of Miami School of Medicine, Dept. of Pathology, P.O. Box 016960, Miami 33101, (305) 325-6437.

Calcium Blockers for the Treatment of Angina Pectoris, Jan. 18, Holy Cross Hospital, Ft. Lauderdale. For information: Jon R. Fichtelman, M.D., P.O. Box 23460, Ft. Lauderdale 33307, (305) 771-8000 Ext. 5828.

15th Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 19, Sheraton Bal Harbor Hotel, Miami Beach. For information: Victor Politano, M.D., 6614 Miami Lakes Drive East, Miami Lakes 33014, (305) 687-1367.

Acute Spinal Cord Injury — Comprehensive Management, Jan. 29-Feb. 5, Vail, Colorado. For information: University of Miami School of Medicine, Post Office Box 016960, Miami 33101, (305) 325-6726.

Continuing Education in Pediatrics - 1983, Jan. 23-27, Diplomat Hotel, Hollywood. For information: Donald H. Altman, M.D., 6125 Southwest 31st Street, Miami 33156, (305) 667-7060.

Round Table Day, Jan. 28, Diplomat Resorts, Hollywood. For information: D.H. Altman, M.D., 6125 SW 31st St., Miami 33156, (305) 667-7060.

Symposium on Intensive Care, Jan. 29-Feb. 5, Vail, Colorado. For information: University of Miami School of Medicine, Post Office Box 016960, Miami 33101, (305) 325-6726.

The 10th Annual Symposium in Pediatric Nephrology; Current Concepts in Diagnosis and Management, Jan. 30 - Feb. 3, Univ. of Miami, Miami. For information: Univ. of Miami School of Medicine, Dept. of Pediatrics, P.O. Box 016960, Miami 33101, (305) 325-6726.

FEBRUARY

Clinical Approach to Exercise Testing, Feb. 3, 4, & 5, Hyatt Orlando, Orlando. For info.: Stephen P. Glasser, M.D., Univ. of South Florida College of Medicine, Box 19, 12901 North 30th Street, Tampa 33612, (813) 974-2880.

10th Annual George F. Paff Seminar, February 4-6, Fort Lauderdale. For information: Univ. of Miami, Division of Continuing Medical Education, P.O. Box 016960, Miami 33101, (305) 547-6716.

Third Annual Treasure Coast Medical-Surgical Review, Feb. 5-6, Dodgertown Conference Center, Vero Beach. For information: John L. Rodgers, M.D., P.O. Box 573, Vero Beach 32960, (305) 567-9711.

9th Annual Conference on Anesthesiology, Feb. 5-12, Vail, Colorado. For information: Univ. of Miami School of Medicine, Dept. of Anesthesiology (R370), P.O. Box 016960, Miami 33101, (305) 547-6411.

Internal Medicine 1983 — 18th Annual Postgraduate, Feb. 6-11, Miami Beach. For info.: Univ. of Miami School of Medicine, P.O. Box 016960, Miami 33101, (305) 547-6063.

Topics in Geriatric Medicine, Feb. 10-12, Diplomat Resort and Country Club, Hollywood. For information: Kevin Newman, M.D., (305) 841-5144.

Prostaglandins in Medicine, Feb. 11-12, The Dutch Inn, Lake Buena Vista. For information: Ms. Grace Wagner, University of Florida, Box J-233, JHMC, Gainesville 32610, (904) 392-3143 or 392-3183.

10th Annual Homecoming Symposium, Feb. 11-12, Sonesta Beach Hotel, Key Biscayne. For information: Univ. of Miami School of Medicine, Dept. of Psychiatry (D29), Post Office Box 016960, Miami 33101, (305) 325-6335.

Florida Midwinter Seminar in Ophthalmology, Feb. 14-16, West Palm Beach. For info.: University of Miami School of Medicine, Dept. of Ophthalmology (D880), Post Office Box 016960, Miami 33101, (305) 547-6540.

The 7th Annual Symposium in Clinical Cardiology, "Cardiovascular Pharmacology", Feb. 18-19, Sheraton Sand Key Hotel, Clearwater. For info.: Donald R. Eubanks, M.D., Morton F. Plant Hospital, 323 Jeffords Street, Clearwater 33517, (813) 441-5166.

Conference on the Beach - 4th Annual Family Practice Update, Feb. 21-26, Daytona Hilton, Daytona Beach. For information: Richard W. Dodd, M.D., (904) 258-1584.

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SURGEON - GENERAL & VASCULAR, Board certified or eligible, for association or separate practice in Winter Garden, Florida. Reply: C-1104, P.O. Box 2411, Jacksonville, FL 32203.

STAFF PSYCHIATRIST being sought for the adult service of the comprehensive CMHC in Pensacola, FL. Salary is negotiable with experience. Duties include both inpatient and outpatient responsibilities. Pensacola is located on the Gulf of Mexico, mild climate, year-round recreation, sugar white sand beaches, and a nationally ranked low cost-of-living area. Send vitae and three references to: Personnel Dept., 1221 W. Lakeview Ave., Pensacola, FL 32501-1899 or call Frank Ramos, M.D., (904) 432-1222. EOE/MF

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PATHOLOGIST, Florida licensed, certified AP-CP, 20 years experience wishes relocation in Florida from northern climate for additional two decades of active practice. Write: C-1097, P.O. Box 2411, Jacksonville, Florida 32203.

RADIOLOGIST: ABR certified, training and experience in Diagnostic Radiology, Ultrasound, Nuclear Medicine, Computed Tomography, including some special procedures as Arthrography, hysterosalpingography; also teaching. Would like to job share in private practice or hospital working every other month. Have Florida State Boards. Reply: C-1108, P.O. Box 2411, Jacksonville, FL 32203.

GASTROENTEROLOGIST 32, seeks private practice setting. U.S. graduate, university trained, ABIM, ABGE certified, 3 years staff/academic gastroenterology experience. Proficient endoscopist including ERCP, Sphincterotomy, Sclerotherapy, Peritoneoscopy. Hyperal team experience. Availability negotiable. Reply C-1112, P.O. Box 2411, Jacksonville, FL 32203.

BRITISH F.P. aged 36. (Florida licensed) seeks position in Florida early 1983. Clearwater, St. Petersburg, Tampa areas preferred. Will consider all coastal areas. Available for interview between Oct. 21 and Nov. 2, 1982. Please reply to Michael D. Fine, M.D., 10 Berrymead Road, Cyncoed, Cardiff, South Wales U.K. or telephone Cardiff - 0222-756043.

GENERAL INTERNIST, 31, graduate of top American medical school and residency program, with Florida license, interested in single or multi-specialty group practice in Florida. Available immediately. If interested please contact: Roderick Santa Maria, M.D., 200 S. Birch Road, Apt. 1002, Ft. Lauderdale, FL 33316, (305) 463-3223.

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ESTABLISHED GENERAL PRACTICE in prestigious community of 12,000-15,000 in Winter Springs, FL for sale/lease. Only G.P. serving area. Hospitals nearby. Office furnished and ready to start immediately. Write to FMC, P.O. Box 613, Maitland, FL 32751; or call after 7 p.m. at (305) 886-5361.

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OCALA -Central Florida, office for rent. Modern building, tremendous location, unlimited parking. 1200 square feet. Write or call Professional Village, 2144 E. Ft. King, Ocala, FL 32671, (904) 732-5555.

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FOR SALE: Old medical books, some first edition. For complete list please contact Jess V. Cohn, M.D., 855 S. Federal Highway, Boca Raton, FL 33432. Phone: (305) 426-0166.

FOR SALE BY OWNER: Treadmill-EKG Heart Stress Test Exerciser System. Marquette Electronics CASE computerized unit with Quinton treadmill. Hardly used. Please call (305) 558-2370 or write MDS, P.O. Box 2746, Hialeah, FL 33012.

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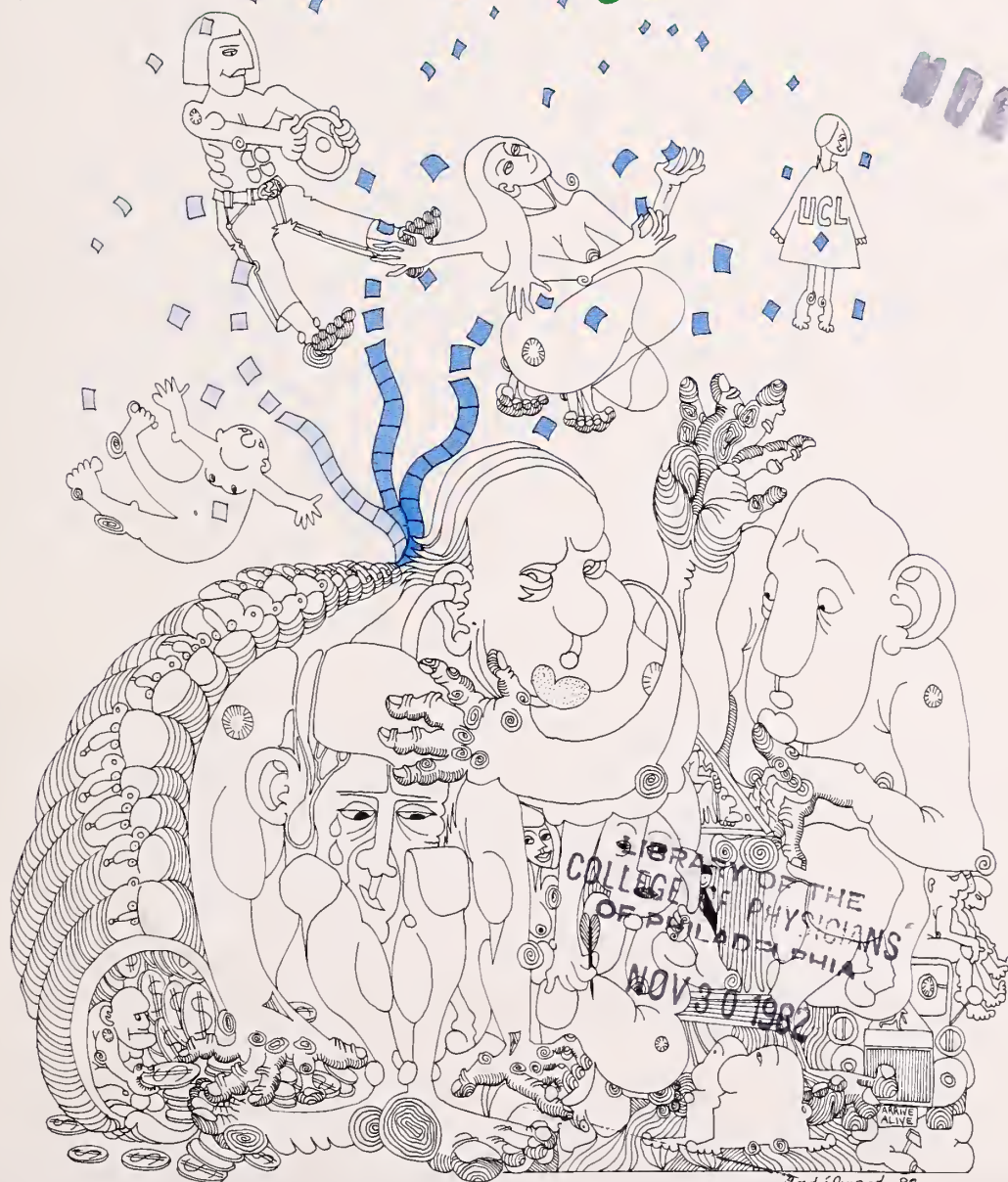
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THE JOURNAL OF THE

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Summary of the FMA Board of Governors Meeting October 14-15, 1982

The following is a summary of the major actions taken by the Board of Governors at its meeting October 14-15, 1982.

THE BOARD:

PROFESSIONAL LIABILITY

Judicial Complaint

Authorized a formal complaint to be filed with the Judicial Qualifications Commission against the Broward County judge who awarded the plaintiff's attorney a \$4.4 million contingency fee in a medical malpractice case as being totally unreasonable, unconscionable and an irresponsible act by an officer of the court.

Direct Contact with Plaintiffs

Authorized the FMA to seek legislation to allow insurance companies to advise plaintiffs directly regarding settlement offers and that this be included as part of the FMA's professional liability legislative proposals for 1983.

FMIT PROGRAM

Psychiatric Coverage

Approved a report regarding changes under the FMIT program limiting benefits for mental and nervous disorders, and directed that a rider for extended benefits for this coverage be made available at a premium level commensurate with the coverage offered and at the most competitive rate possible.

Physicians Treating Family Members

Approved a policy that benefits under the FMIT program not be allowed for physicians treating dependent members of their immediate families.

Pre-Existing Conditions

Approved an amendment to the FMIT plan benefits booklet to be effective November 1, 1982 regarding pre-existing conditions to provide that:

"a pre-existing condition is any condition that exists prior to the effective date of coverage for an eligible employee or his dependent."

1982 RELATIVE VALUE STUDIES ADDENDUM

Authorized publication of an addendum to the 1982 *Florida Relative Value Studies* to include the following:

- Special Services and Reports sub-headings as used in CPT-4;
- No modifiers will be assigned relative values unless there is existing supportive data;
- A comprehensive list of modifiers and special billing codes in each section;
- Clarification of the abbreviations "PC", "PS", and "TS";
- Replacing "RNE" (relative value not established) with a relative value when a correlating procedure is determined between the 1975 RVS and CPT-4;
- All follow-up days on codes with asterisks will be removed.

THE 1982 FMA ASSESSMENT DELIN- QUENCY DATE

Determined that the provisions in the FMA Bylaws applicable to the collection of dues and assessment for members of the assessment and provisions dealing with delinquency payment be applied to the collection of the 1982 assessment for professional liability.

The delinquency date for the assessment will be April 1, 1983. If payment is not received before October 31, 1983, the delinquent member shall be subject to loss of membership in the Association.

1983 FMA BUDGET

The Board approved the proposed budget for 1983 with a total income and expenditures in the amount of \$3,197,000.

APPOINTMENTS AND NOMINATIONS

Joint Underwriting Association

Designated Robert J. Brennan, M.D., Ft. Lauderdale, as the Association's representative on the JUA Board for another year with William J. Dean, M.D., St. Petersburg, as his alternate.

AMA Councils

Enthusiastically endorsed nomination of the following physicians to the AMA Board of Trustees for election or appointment to AMA Councils in 1983:

- Warren Lindau, M.D., Miami, Council on Scientific Affairs;
- J. Lee Dockery, M.D., Gainesville, Council on Medical Education;
- Robert E. Windom, M.D., Sarasota, Council on Legislation or Board of Directors of AMPAC.

FMA AWARDS

Approved the following awards to be continued for 1983 as part of the FMA public relations activities:

- Excellence in Medical Journalism;
- Medical Speakers;
- Medical Malpractice Prevention.

Information regarding each of these awards will be sent to county medical societies in early November for nominations to be submitted for consideration for the 1983 awards to be made in conjunction with the Annual Meeting in May.

1984 FMA ANNUAL MEETING

Approved the finalization of contractual arrangements for the 1984 FMA Annual Meeting to be held at the Palace Hotel in Lake Buena Vista, Florida with the understanding that the costs of holding the meeting at this location will be higher than costs incurred in meetings held in the South Florida area.

SOUTHERN MEDICAL ASSOCIATION

Approved FMA co-sponsorship of the Southern Medical Association Leadership Conference to be held March 18-20, 1983 in Long Boat Key, Florida.

CUBAN MEDICAL ASSOCIATION CONGRESS

Approved FMA co-sponsorship of the 1983 Cuban Medical Association International Congress to be held June 27-July 4, 1983 in Miami, Florida.

FMA MEDICAL TRAVEL SEMINARS

Approved medical travel seminars for 1983 to be sponsored by the FMA and the Auxiliary including the 8-day Jamaican Adventure, January 30-February 6; the Australian Adventure, March 5-12; the Orient Express Adventure, August (exact dates to be determined); and the Dutch Waterways Adventure, September (exact dates to be determined).

COUNCIL AND COMMITTEE REPORTS

The Board of Governors reviewed the reports and recommendations of FMA Councils and Committees and took the following actions:

COMMITTEE ON PROFESSIONAL LIABILITY

The Board received a report on the extensive activities that are currently being carried out in support of the 1983 legislative program for professional liability reform. The Board requested the Committee to continue to study all viable proposals for consideration for inclusion in the FMA's program to be introduced in the 1983 Session of the Legislature. The Board expressed its commendations to T. Byron Thames, M.D., Chairman of the FMA Professional Liability Committee for his many contributions for the implementation of the FMA's goals relative to the professional liability reform and further expressed appreciation to Jerry D. Moore, M.D., for his contributions in serving as a member of the Insurance Commissioner's Council on Malpractice.

AMA DELEGATES

The Board reviewed the report of the Florida AMA Delegation regarding the activities of the Florida Delegation at the 1982 Annual Meeting held June 13-17, in Chicago and the major actions of the House of Delegates including:

Board of Trustees

The Board commended the entire Delegation and representatives of the FMA Auxiliary for their successful efforts in the election of Rufus K. Broadaway, M.D., Miami, to the AMA Board of Trustees.

Other Election Results

The following physicians were elected to the offices specified:

President-Elect

Frank J. Jirka Jr., M.D.

Speaker

Harrison L. Rogers Jr., M.D.

Vice Speaker

James E. Davis, M.D.

Trustees

Rufus K. Broadaway, M.D.

John J. Coury Jr., M.D.

F. William Dowda, M.D.

Hubert A. Ritter, M.D.

Southeastern Delegation

The Florida Delegation continues to participate in the Southeastern Delegation. Activities at the Annual Meeting included a breakfast caucus on Sunday morning in which candidates for elective office were interviewed and major items of business to be addressed by the House were discussed. A reception sponsored by the Delegation was held Monday evening.

Resolution

The Florida Delegation introduced Resolution 54 which asked that the AMA representatives to the Accreditation Council for Continuing Medical Education seek reversal of the

action taken by the ACCME to defer development of a handbook to accompany the *Essentials of Continuing Medical Education Accreditation*.

Report E of the Council on Medical Education was adopted as amended in lieu of Resolutions 54 and 60. The amendment to Report E is as follows:

"The proposed *Essentials* be approved contingent upon the approval by the House of Delegates of *Guidelines* to be used by the ACCME in its accreditation of national sponsors of continuing medical education."

House of Delegates' Actions

The House of Delegates considered a large range of subjects covering all aspects of medicine with some of the highlights as follows:

Development of a National Health Policy

A great deal of discussion took place between the delegates over Report S of the Board of Trustees which outlined a new AMA program to develop a national health policy, including the development of basic principles to reflect the private sector's philosophy on health care policies, the development of a health policy plan containing the private sector's view of what should happen in the health field, providing the basis for the private sector to determine the national agenda for dealing with health issues.

The House of Delegates will monitor closely the implementation of this effort.

Federal Trade Commission

Several resolutions were adopted which, in essence, will support the AMA's efforts in obtaining passage of legislation; amending the FTC Act to clarify that the FTC has no jurisdiction over the professions; prohibit the FTC from preempting state laws; and cause the FTC to make major procedural reforms.

CME Accreditation

The House voted to approve the *Essentials for Accreditation* contingent upon the approval by the House of Delegates of *Guidelines* to be used by the ACCME in its accreditation of national sponsors of continuing medical education.

Insurance Assignments

The House accepted a resolution calling for the AMA to investigate the frequency of erroneous payments to insurance beneficiaries instead of to physicians to whom they have assigned such payments and seek, in consultation with appropriate agencies, the minimizing or elimination of such problems.

Alternative Proposals for Health Planning

The House voted to establish as a policy of the AMA: support of health planning on a local and voluntary basis with considerable physician input; support of implementation of appropriate local health plans by the cooperative effort of the local community; and the support of the concept that if regulatory functions should arise, they should be conducted independently of the planning process. Also, the House voted to continue the effort to repeal the federal Health Planning Act.

Physician-Patient Relationship

The House voted to reaffirm the policy that physicians are free to choose their patients, their associates, and the environment in which to provide medical services, except in emergencies.

Postpayment Utilization Review

The AMA was instructed by the House to promote a change in Medicare regulation and policy to limit postpayment utilization review and requests to recoup payments to claims that are no more than two years old from date of submission, except in cases of suspected fraud.

Designation of Areas of Medical Need

The AMA is to request the federal government to consolidate the federal designation process for identifying areas of medical need and coordinate the process with state agencies as well as ask for state and local medical society approval of the designated underserved areas, and to establish rules requiring automatic cessation of federal subsidies in the final year following the year in which manpower guidelines are met unless the subsidy is for medical education purposes.

Drug Paraphernalia

The House adopted a policy opposing the manufacture, sale and use of drug paraphernalia.

Medical Education

A comprehensive report based on 36 recommendations on the topics of generalism and specialism, preparation for and admission to medical school, medical schools and undergraduate medical education, specialism, graduate medical education and specialty boards, licensure, CME and graduates of foreign medical schools was passed.

Medical Licensure

The AMA is to urge each state medical licensing board to permit graduates of LCME (Liaison Committee on Medical Education) accredited programs to be licensed for the independent practice of medicine prior to the second year of residency training.

Hospital Accreditation	The House adopted a policy that hospital accreditation procedures be utilized primarily to evaluate and improve the quality of patient care, and opposed rigid, uniform, mandatory requirements for the hospital, its governing board, attending staff, and committees.	Licensure by Endorsement	Requested that the State Board of Medical Examiners prohibit the issuance of medical licenses by personal endorsement in lieu of presentation of an actual degree from a medical school.
Computerized Information Network	The GTE Telente Medical Information Network, which was unveiled at the meeting and is presently undergoing tests, will provide four data bases, licensed and maintained by the AMA. Through the use of existing telephone lines, these data bases will provide information on drugs, disease, socio-economic bibliographies and medical procedure coding and nomenclature, as well as an electronic mail system offering instant transmission of written messages between subscribers.	Utilization and Quality Control Review	Urged Florida physicians to make themselves available to their county medical societies for utilization and quality control review.
COMMITTEE ON MEMBERSHIP DEVELOPMENT	Approved a recommendation that emphasis be placed on membership of medical students and residents at the local, state, and national levels and that state and local medical society's dues be kept as low as possible for medical students in order to encourage their participation.	PMUR in Medicare and Health Insurance Review	Determined that in light of actions by the FTC and rulings of the United States Supreme Court that all peer review activities including health insurance review and Peer Medical Utilization Review be discontinued until such time as clarification is received as to the legal implications of these activities.
Medical Student/Resident Membership		Workers' Compensation	Expressed strong opposition to any changes in the Workers' Compensation Law which would provide for physicians to be reimbursed solely on a negotiated fee schedule basis and directed that if this issue is raised during the 1983 Legislature that the FMA sponsor legislation to eliminate all references to a physician fee schedule in the Workers' Compensation Law and require, instead, that physicians be reimbursed on a usual and customary fee basis.
AMA Membership Identification	Encouraged continued efforts to increase AMA membership by including a statement on the AMA dues statements regarding the importance of participation in the AMA in order to advance membership at the national level and further that a special identification of AMA members be provided for badges at the FMA Annual Meeting.	COUNCIL ON SPECIALTY MEDICINE	Endorsed the concept of a clinic for the provision of ongoing medical care for Medicaid eligible children such as the one being developed in Hillsborough County.
COMMITTEE ON IMPAIRED PHYSICIANS	Authorized development of an inter-professional impaired professional program in cooperation with the Florida Osteopathic Medical Association, the Florida Veterinary Medical Association, and the Florida Dental Association under the auspices of the Florida Medical Association and the Florida Medical Foundation.	Pediatric Clinic	
Inter-Professional Program		Recognition Program	Approved a status of full recognition for the International College of Surgeons, Florida State Surgical Division under the FMA's specialty group recognition program.
Dolores A. Morgan, M.D.	The Board expressed sincerest commendations to Dolores A. Morgan, M.D., for her outstanding contributions to the impaired physician program in serving as Medical Director of the program.	Florida Allergy Society	Approved recognition of the name change of the Florida Allergy Society to the Florida Allergy and Immunology Society.
COUNCIL ON MEDICAL ECONOMICS		Trauma Center Law	Approved FMA seeking changes in the Trauma Center Law passed during the 1982 Session of the Legislature to allow for more flexibility in the verification standards.
Clean Indoor Air Act	Expressed FMA support of the AMA Model Clean Indoor Air Act.	Hospital Licensure Law	Approved the recommendation that FMA seek changes in the Hospital Licensure Law returning authority to the medical staffs to approve medical staff privileges.
Medicare Assignments	Supported legislation to repeal Florida statutes which require physicians to state whether they do or do not accept Medicare assignments when renewing medical licenses.	Optometrists Use of Drugs	Voted to continue FMA opposition to legislation which will allow the use of drugs by optometrists.
		Physical Therapist Act	Expressed continued opposition to a re-writing of the Physical Therapist Act if it broadens the scope of their practice and takes them out from under the prescription requirements of a physician.

COUNCIL ON MEDICAL SERVICES

Public Health Program

Strongly encouraged the development of accredited graduate programs in public health and offered the voluntary assistance of the FMA Committee on Public Health in an advisory capacity to graduate public health education and research.

Public Health Officer

Required the Secretary of the Department of HRS to officially designate the Director of the State Health Program Office as the State Health Officer and that such an officer hold an M.D. or D.O. degree.

Public Health Funding

Determined that the FMA work with the legislature and the Department of HRS toward achieving a more practical solution of distributing public health services and funds.

Environmental Hazards

Recommended to the Department of HRS that it obtain health staff with appropriate expertise in handling environmental health hazards and that the Department establish a section on environmental health to be coordinated with the new section on epidemiology.

School Health Education

Approved FMA support for appropriate measures to increase the exposure of high school students to educational information on current health problems which may affect their lifestyles in the future.

Legal Drinking Age

Endorsed proposed legislation to raise the legal drinking age in Florida from 19 to 21 years of age.

JUDICIAL COUNCIL

Seating of Alternate Delegates

Approved a proposed Bylaws amendment to the House of Delegates at its meeting in 1983 that would allow for the seating of Alternate Delegates as called for by Resolution 81-11 introduced by the Hillsborough County Medical Association and adopted by the House. The RESOLVE of Resolution 81-11 called for the Board of Governors to prepare an amendment to the Bylaws patterned after the American Medical Association to provide for the flexible interchange of Delegates and Alternates to participate in meetings and sessions of the House of Delegates with full privileges. The following change in the Bylaws is proposed.

CHAPTER IV, SECTION 11 TENURE OF DELEGATES

~~A delegate who has been officially seated at a meeting of the House of~~

~~Delegates shall remain a delegate of the component society which he represents throughout all sessions of that meeting, and his place shall not be taken by any other delegate or alternate.~~

Each delegate seated at an Annual Meeting shall serve until the next Annual Meeting and shall serve at all interim or called meetings between Annual Meetings, unless the component society by certification of its president or secretary duly designates a different delegate.

CHAPTER IV, SECTION 12 ALTERNATE DELEGATES

Each component society shall select alternate delegates corresponding in number to the delegates to which it is entitled, and shall designate to the secretary of the Association the order in which they are to serve.

Each alternate not seated as a delegate at the Annual Meeting shall continue to serve as an alternate until the next Annual Meeting and for all interim or called meetings between Annual Meetings, unless the component society by certification of its president or secretary duly designates a different alternate.

Qualified Alternate Delegates may be seated for a Delegate who is unable to attend the Annual Meeting or any session of the House of Delegates. The component society may seat an Alternate Delegate for the Delegate provided that the Alternate Delegate deposits with the Credentials Committee a certificate signed by the President or Secretary of the component society stating that the Alternate has been properly selected to serve. An Alternate who has been seated at any single session of the House of Delegates shall serve throughout that session and may not have his place taken by any other Delegate or Alternate; provided further, that once an Alternate has been seated for a Delegate during any session of the House of Delegates, that Alternate shall be the only Alternate thereafter eligible to serve for that particular Delegate at subsequent sessions of the House of Delegates during the Annual Meeting.

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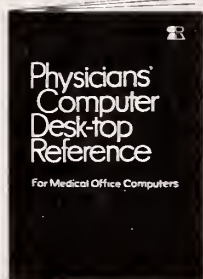
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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication. Abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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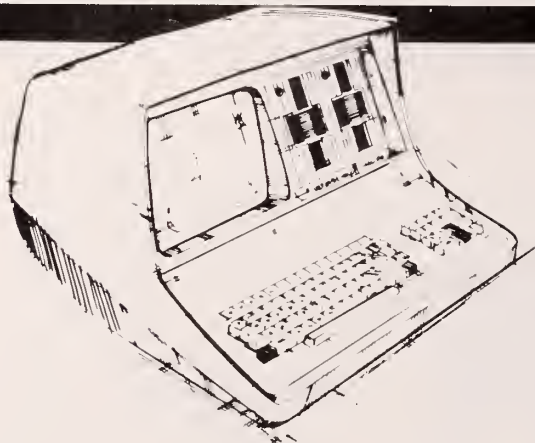
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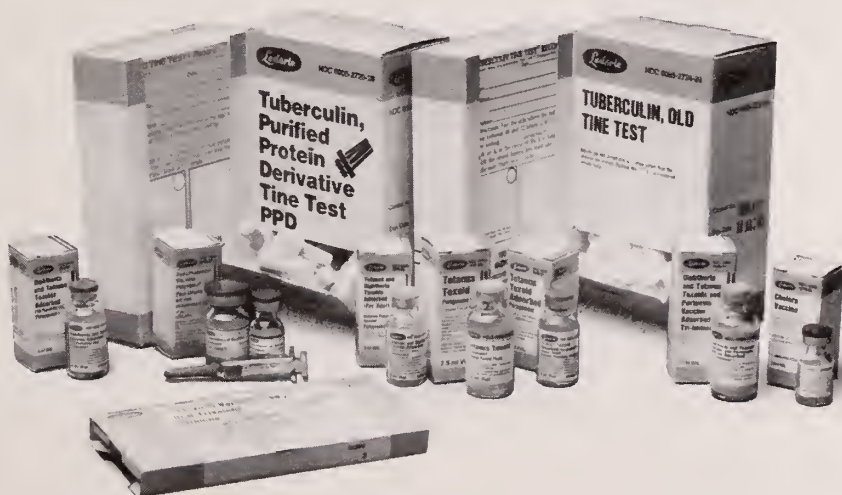
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COVER

This month's cover of *The Journal* was designed by Andre Renard, M.D., a Plastic Surgeon practicing in Jacksonville. The cover depicts our lead article "The Meal Ticket Syndrome" by James N. Sussex, M.D. of Miami, which begins on page 919.

Dr. Renard shows the patient in the center who appears to have everything (wealth, successful business, education, status car, etc.) but is still unhappy. His doctor is at his side. Society is looking at him puzzled, unable to understand how such a successful person could be depressed. Above the patient is his wife. Her four hands show her to be busily involved in many things. His children are all in their own worlds, not giving him the attention he needs. Flowing through are meal tickets all around which summarize his feelings as being just a meal ticket for his family.

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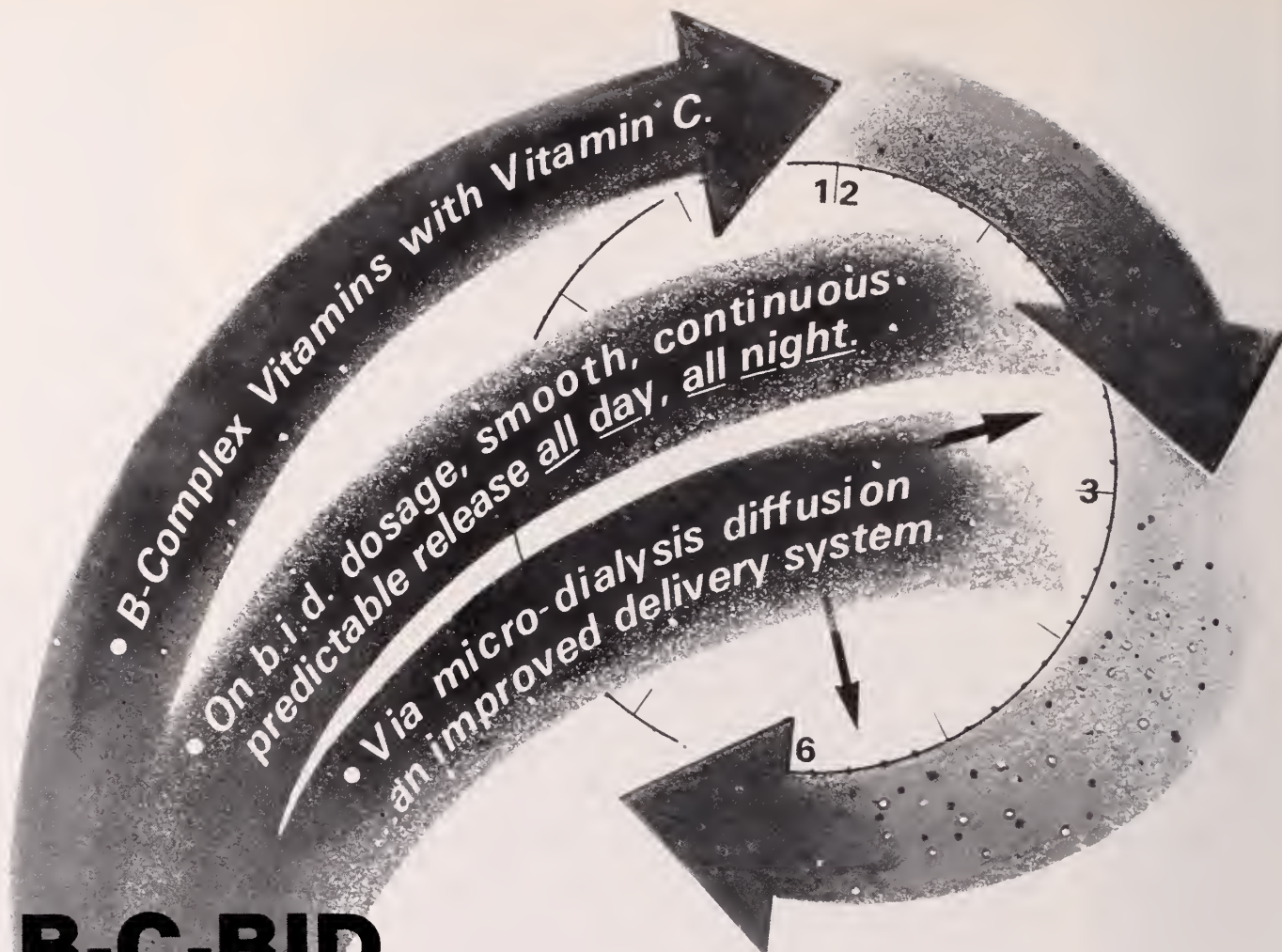
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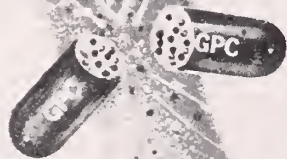
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Reaction to injury

Much of what we learned in medical school has meaning and application throughout our lives as physicians. Continuing new advances add to our basic knowledge, but the bulwark of our educational base remains relevant to our practice.

On a personal note, one particular aspect of my medical school education not only applies to human patients but also may be compared to the medical profession. My pathology professor, Doctor Wiley D. Forbus, was an author of several textbooks entitled "Reaction To Injury". He taught how the body is able to withstand multiple types of injury and also how the body may be consumed by such injury. Let us look at our profession today and see where it is attacked by "injury" or assault of various types and how it might react.

What are some of these injuries? First, the media in all forms may report medical events in a distorted, inaccurate manner that leads the public to look askance at our profession as a whole. Future correction by the media to such misinformation is virtually never seen by the public.

Secondly, we are surrounded by multiple disciplines that assist us in delivering medical and surgical services to our public. These are our allied medical groups and nonphysician providers which independently serve specific functions that collectively compose the "Health Care Team" in today's medical practice. There are some individuals in such groups who feel that their expertise entitles them to broader roles in medical care, and they are attempting to erode the role of the physician as the captain of this team.

Thirdly, the problem related to our professional liability situation has generated such an emotional



response by some that our credibility as medical leaders is threatened. Certain adversative professional members are actively trying to extend their vehemence to include our total medical profession for the cause of bad results incurred by only a few. Ironically, most attacks are made where there never was negligence.

These are some of the exogenous injuries our profession is facing. What are some endogenous injuries?

As a profession we must clean up our own act. Reports in newspapers recently estimate 10-15% of American physicians are chemically dependent. The report claims one-third of American physicians are heavy consumers of alcohol and drugs compared to one-fifth of the general population. Allegations of physicians assuming the role of entrepreneurs and technical experts rather than practicing the art of medicine with compassion and concern for human needs causes the public to pause and to consider a second opinion of the medical profession.

How can we best react to these "injuries"? Our education in medicine has taught us that the healthier the boy, the better the response to injury. The same holds true for the health and preservation of our profession. As I have stated on previous occasions, our house of medicine has strong floors (county medical societies), strong walls (state medical associations), but a weakened roof (American Medical Association). The fact is that only 50% of our profession's potential strength is providing the total defense we must muster to withstand the assault from our adversaries. Therefore, we must strengthen the "roof" of our house by the 50% of our colleagues who are not participants joining the rest of us in membership and financial contribution.

Secondly, we need a unified voice in order to produce a strengthened community to withstand these injuries facing us. No team ever wins if only half the players participate.

The vital importance of the involvement of each individual member in order for us to succeed is best illustrated in the following passage published in the August, 1981 issue of the *Polk County Medical Association Bulletin*.

"What Makes A Team A Success?"

Svsn though my typswritsr is an old modsl, it works quits wlll xcspt for ons of ths ksys.

I havs wishsd many timss that it worksd prfctly.

It is trus that thsrs ars forty six ksys that function wlll snough but just ons ksy not working makss ths diffrsncs.

You may say to yoursslf, "wlll, I am only ons prsrson. I won's maks or brsak this tsam and its program". But it doss maks a diffrsncs bscauss a tsam to bs affctivs nssds ths activs participation of svry prsrson.

So ths nsxt tims you think you ars only ons prsrson and that your efforts ars not nssdsd or apprsciatsd, rsmmbrr mv typs-writsr and say to yoursslf, "I am a ksy prsrson on this tsam, and I am nssdsd vsry much."

I know of no better way to illustrate the importance of each member's participation in any group.

I am optimistic that as a profession we can stand together strong against the attacks upon our house, from without as well as from within. However, we cannot prevail if each of us does not do his part to add the necessary link that bonds us together as one to provide strength for all.

Robert E. Windsor, M.D.

P.S. If you are a member of the total organization of medicine, get just one colleague who has not joined the AMA and our house of medicine will be strong enough to withstand any assault.

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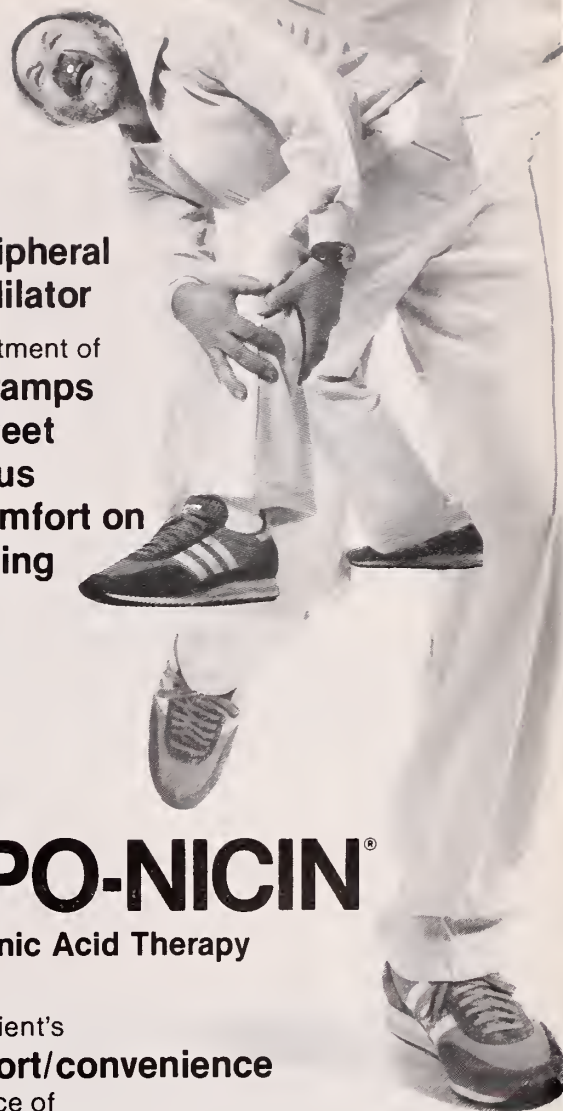
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DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

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Niacinamide 75 mg.
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• no narcotic risk, red tape, records	• narcotic precautions required
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References:

1. Hart FD, Huskisson EC, Ansell BM in Hart FD (editor): Drug Treatment of the Rheumatic Diseases, 2nd Ed, Adis Press, Balgowlah, Australia, 1982, p. 30.
2. Rondeau PL, Yeung E, Nelson P: Canad Dent Assoc J 46:433-439, 1980.
3. Selwyn P and Giles AD: Br Jrl of Clin Practice, Supplement 6, Safe and effective analgesia following dental surgery: A comparison of brufen and distalgic. Pg 87-90, 1980.
4. Taina E: Curr Med Res Opinion, 7:423-428, 1981.



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INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain. Treatment of primary dysmenorrhea.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angio-edema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally, however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS: Incidence greater than 1%. **Gastrointestinal:** The most frequent adverse reaction is gastrointestinal (4 to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS). *Incidence 3% to 9%.

Incidence less than 1 in 100. Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome and alopecia. **Special Senses:** hearing loss, amblyopia (blurred and/or diminished vision, scotomata and/or changes in color vision) (see PRECAUTIONS). **Hematologic:** neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura eosinophilia, decreases in hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Allergic:** syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasms (see CONTRAINDICATIONS). **Renal:** acute renal failure in patients with preexisting significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria. **Miscellaneous:** dry eyes and mouth, gingival ulcers, rhinitis.

Causal relationship unknown. Gastrointestinal: pancreatitis. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri. **Dermatologic:** toxic epidermal necrolysis, photo-allergic skin reactions. **Special Senses:** conjunctivitis, diplopia, optic neuritis. **Hematologic:** bleeding episodes. **Allergic:** serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (sinus tachycardia, bradycardia, and palpitations). **Renal:** renal papillary necrosis.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Dysmenorrhea: 400 mg every 4 hours as necessary

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for the relief of pain. Do not exceed 2,400 mg per day.

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Times are changing

In a recent issue of the *New England Journal of Medicine*, John K. Iglehart pointed out:

The nation's teaching hospitals — complex, expensive, and dependent on public support to sustain their many activities — are heading into more stressful times that will force many of these institutions to question and perhaps dramatically alter their basic operations. Like any set of American institutions that prospered in the bountiful times of yesterday, most teaching hospitals are resisting and will continue to resist major change; yet, given the policy directions of government and the expressed concerns of private insurers over cost shifting, maintaining the status quo no longer seems a viable option for many of them.

In contemplation of cost effective changes what part of the teaching hospitals' basic operations is the most vulnerable? The residency programs are high on that list in many places.

In the 1950's and 60's it was not difficult to convince hospital administrators and boards of trustees of the advantages of having internship and/or residency training programs in their institutions. Not only did these add to the quality of care but, even more important from the standpoint of the institutions' administration, they contributed significantly to caring for the heavy indigent patient load.

Such help came cheap; prior to World War II the first-year intern's salary averaged \$2,976 per year in the hospitals affiliated with a medical school and only a little more in the others.

On balance the intern (and resident) purchased his/her education and training in those years through service at a rate that clearly favored the hospital. Hospitals understood this and made great effort to create and fill authorized positions even if they had to resort to poorly prepared foreign medical graduates.

But times have changed. No longer are interns and residents "cheap help". By 1970 beginning stipends were up to an average of \$9,096 per year, and in 1982-83 the nationwide average has been reported to be \$18,930. There are, of course, incremental increases approximating \$1,200 for each additional year of residency.

At the same time the service workload of the resident—his repayment to the parent institution—has been going in the opposite direction. The Task

Force on Graduate Medical Education of the Association of American Medical Colleges stated:

Graduate medical education has evolved into a formal phase in the preparation of a physician which is more like university based graduate education in other professions and disciplines than on-the-job training. However, because it is predominantly conducted in the work place of medicine, rather than in university classrooms and laboratories, the controversy about resident status—student or hospital employee—remains unresolved.

Taking a position that education is not their business, hospitals are showing increasing reluctance to begin, expand or even in some cases to continue housestaff training. Further encouragement in this retrenchment is being offered by some of the specialty societies of medicine for an entirely different reason — a perceived coming surplus of practitioners of their specialty.

Unfortunately, true facts on the economics of graduate medical education are hard to come by. While it is probable that upper level trainees in some of the specialties do repay the hospitals in services rendered, there is evidence that in many cases—especially in the primary care specialties with heavy emphasis on ambulatory care—this is not the case. There is need for more clarification of this point by some well carried out studies.

Whatever the causes, for some time the gap has been narrowing between the number of first year postgraduate (PGY-1) positions offered and the number of medical school graduates seeking those openings. In the most recent (1982) match of applicant with position, the number of U.S. graduates applying was 292 more than in 1981 while the number of positions offered by hospitals *decreased* by 31. Not only is the number of U.S. graduates increasing (and will continue to do so for the next few years), but so are the numbers in the competing groups: U.S. graduates of foreign medical schools, graduates of osteopathic medical schools and alien foreign medical graduates. In all, the total number of initially applied for PGY-1 positions in 1982 was 22,126 while the number offered in the match was 18,300.

So, while medical school seniors and others seeking residency positions have long enjoyed a "buyer's

market", that day seems to have passed. The bartering advantage has shifted to the sponsoring institutions. In such a situation it seems unlikely that the hospitals will not exploit this position and seek a *quid pro quo* of the resident. This, it would appear, could take either or both of two forms: greater service workload demand or retrenchment of stipend. Since the accrediting agencies will vigorously resist the former, the latter course appears more likely.

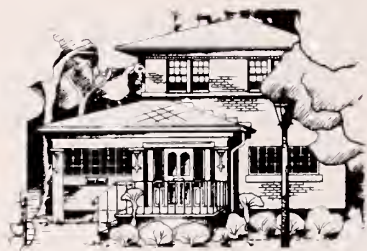
Such action could have a profound effect upon the lifestyle residents now enjoy. Furthermore, this economic deprivation could compound for future residents facing other serious economic setbacks such as rising medical school tuitions, reduced availability of loans and scholarships and—perhaps the most devastating of all—a reduced opportunity to

"moonlight" due to a more adequate local physician supply.

Many innovative means of coping with stressful times will doubtlessly emerge. One interesting possibility might be the development of more one-on-one agreements between a resident and a future practice location for prepayment for services, secured by a binding agreement. Geographic distribution might then be a beneficiary.

This likely competitive scramble for residency positions, not unlike that for medical school places, will certainly bring about many changes in the status quo. These changes must be monitored with great care by physicians, hospitals and medical educators.

Kenneth E. Penrod, Ph.D.
Tallahassee



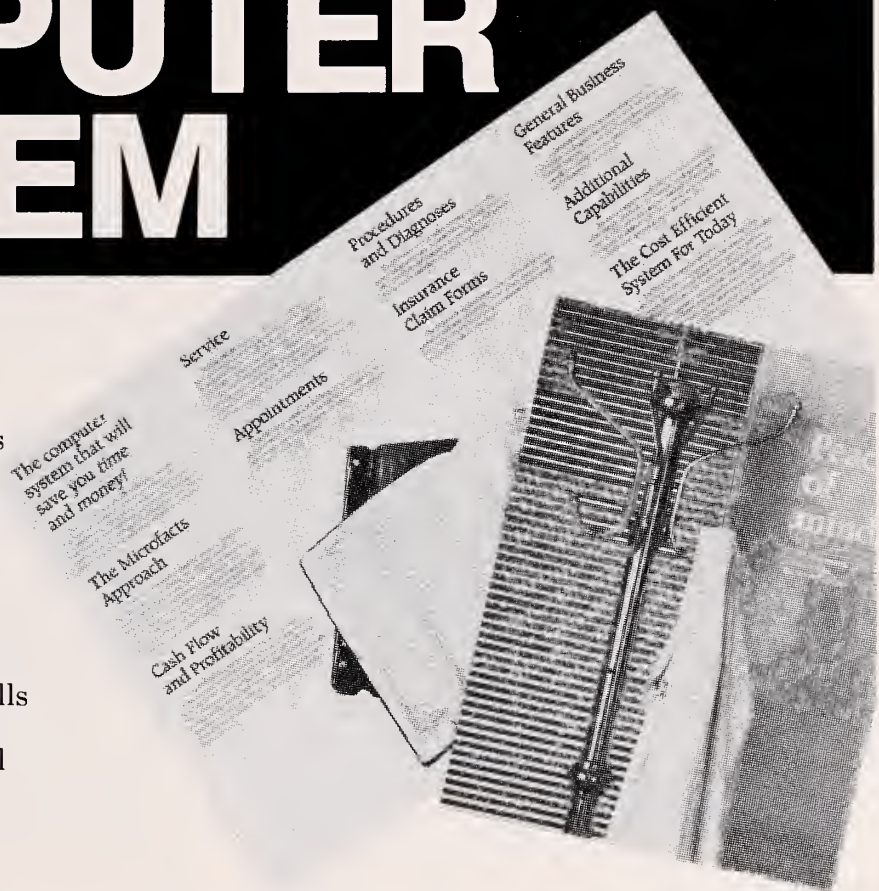
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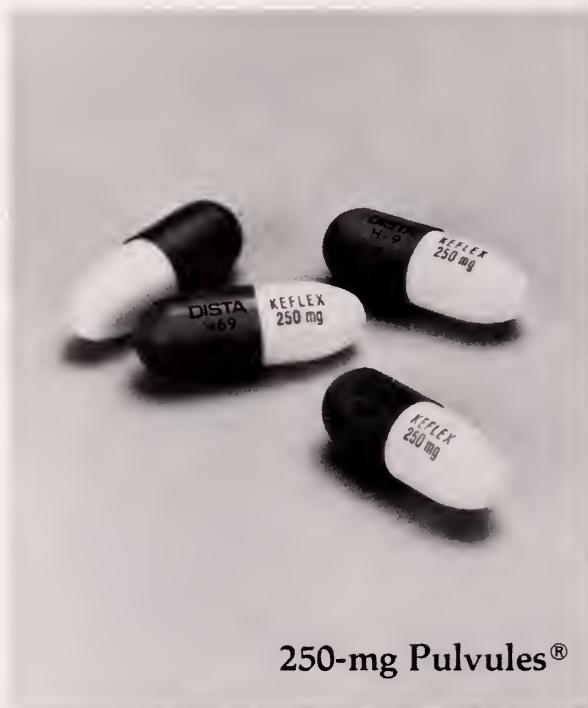
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The meal-ticket syndrome

A masked dependency reaction of the middle years

James N. Sussex, M.D.

ABSTRACT: Successful men in middle age may present with a variety of somatic symptoms for which no organic cause can be found. Variants of this syndrome include neglect of work, problem drinking, sexual indiscretions, and other behavior changes. With adequate exploration these patients frequently reveal that they feel unappreciated and exploited. Although there is an undercurrent of depression, unexpressed anger at not having dependency needs met seems the most important etiologic factor. Prognosis is favorable if treatment is focused on these underlying feelings.

Mr. Smith was referred by his personal physician, an internist, with the almost apologetic request that I not regard this as the usual psychiatric referral. The physician, whom I'll call Dr. Johnson, explained that he and the patient had long been friends, frequent golfing companions, and members of the same church and country club. Their wives were on friendly though somewhat more casual terms. They lived a few blocks apart in a fairly affluent but generally conservative community.

Mr. Smith, senior vice president of a major bank in the city, was in his mid 40's. He was widely recognized as a civic leader, good family man and a fine citizen. Dr. Johnson had been his personal physician for ten or so years and finally, about five years before, had persuaded Mr. Smith to submit to a physical examination and certain other diagnostic procedures each year. It was difficult to get him into the office when the annual checkup was due. He had always been in good physical condition, although with a tendency to develop a bit of a pot if he didn't get enough exercise. He looked at least five years younger than his actual age, and his physical examination and laboratory findings reflected this. Dr. Johnson regarded him as a man who enjoyed his work and took great pride in his family—generally as the kind of person any man would like to be at the prime of his life.

Now, for the first time, he had come up with a complaint. Some three weeks prior to the referral, he had mentioned to Dr. Johnson that he had not been feeling quite up to par lately and perhaps he should drop in for a check-up. At the office Dr. Johnson asked what was bothering him and was a bit surprised because he was not his usual precise self. He had always answered questions in exact terms and in a straightforward manner, but on this occa-

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sion he was surprisingly vague. He guessed he had been sort of off his feed lately. Anyway, he did not enjoy his food as much as he used to. He seemed to tire more easily and because of this had been going to bed earlier than usual. He had not been sleeping well and had been awakening in the morning feeling incompletely rested and reluctant to get going. A decisive person all his life, he had been having difficulty lately in making decisions and got irritated at himself on that account. He also had been finding himself at these times getting edgy with his wife and children, even though he recognized that he hadn't any good reason to be so.

The thing that had worried him most, perhaps, was that he actually dreaded going to the bank, something quite different for him since he had always enjoyed his work thoroughly. Once he arrived there, he found it hard to get started with the day's work, "piddling around" a great deal and generally wasting time. He had become more and more irritable, snapping at his secretary in a way he had never done before. He did not like himself this way but had not seemed able to do anything about it.

He could give Dr. Johnson no definite physical symptoms that bothered him, even on specific inquiry. Physical examination showed everything in good order, although the doctor entertained the thought that he was perspiring more than usual. Dr. Johnson, by this time watching him closely, decided that his expression was less animated than usual and that this must be significant. When the electrocardiogram and laboratory tests turned out entirely within normal limits, he decided to ask Mr. Smith to come in for a talk. This visit occurred some ten days after the first one.

Because Mr. Smith appeared rather "down," Dr. Johnson commented that perhaps he had been depressed lately. Mr. Smith acknowledged this to be true but attributed it immediately to the fact that he had not been feeling well. As the conversation went on, Dr. Johnson noted that almost every feeling he suggested he might have Mr. Smith admitted having but immediately denied that it could possibly have any significance except as it related to the fact that he had not been up to par lately.

When I first saw him I began inquiring into those areas of Mr. Smith's life that might be causing him worry and concern. Because of his irritability at the office, I asked how business had been going lately, and Mr. Smith told me fine, never better. But, he added, this had not seemed to fire him with enthusiasm as it once would. Here this inquiry reached a dead end. Then I began exploring his family life, though I had been assured by Dr. Johnson that there were no problems. I asked about his wife and children. "They're all fine," he said—wife involved in all sorts of activities, kids the same. But

he told this with little zest and having been told of his deep pride in his family, I chose to follow this up more fully. Finally he stated that his wife had really been too involved in her own activities to have much time for him, that the only time the children seemed to talk to him was when they needed money, that "sometimes lately all I feel like is a meal ticket for the whole darned family."

Description of patients • Over the years I saw many men with a similar story. I was impressed by the fact that ultimately they described themselves in words which conveyed the feeling that they meant nothing more than a meal ticket to their families and I decided to call the condition, unofficially of course, the meal-ticket syndrome. The syndrome takes many forms. It can present as an illness with obvious emotional significance such as depression, or with symptoms of much less obvious psychiatric import such as disinterest, boredom, or irritability. It can present as a behavioral disturbance such as excessive drinking or temper outbursts or infidelity. But perhaps the commonest presenting symptoms are, broadly speaking, in the psychosomatic area—sometimes specifically referable to an organ system, like epigastric distress or tachycardia and palpitation, but even more likely to be vague and nonspecific, like easy fatigability or a feeling of generalized body tension. Gone into deeply enough, the common denominator turns out to be feelings relating to inadequately met dependency needs—disappointment, anger, guilt, and ultimately, sometimes, withdrawal and despair.

The men I have seen with the meal-ticket syndrome are almost always better than average citizens. They have a strong sense of responsibility and characteristically discharge their obligations well. In fact, many are compulsively attentive to such obligations and seem to show little need for being any other way. For many years the feeling of achievement and success, and the admiration and honor that frequently come from such a career, may be adequate gratification and the man seems to thrive under this back-breaking load. Somewhere along the line, these rewards alone may not be enough and because this person, by his very nature, is unlikely to be able to admit easily that he is tired of meeting the expectations of everyone around him, of always being the strong and adequate father figure to his family and his employees and his clients, he may develop symptoms that say it for him.

Underneath the top layer of emotional maturity in everyone are various other layers derived from earlier stages of emotional development. At least two of these layers have to do with a need to be taken care of and a need to do what we want to do when we want to do it. The kind of man I am

discussing has characteristically denied, even to himself, that he needs to be taken care of and, to a considerable degree, he has also denied his need to act on his natural impulses. Although he may be regarded, and may regard himself, as being free to do anything he likes, he is really bound by the need to conform to the expectations of those around him—to be, in a broad sense, a “good boy.” Underneath, though, he resents having to carry responsibility and resents those people who expect him to. He feels unappreciated and exploited and wants to retaliate against those who seem to take advantage of him. But “good boys” don’t resent people or retaliate against people, so he also feels a vague sense of guilt at having such feelings at all—even if he does not act on them directly.

Causative factors • Such reactions tend to occur when two things happen in a man’s life: first, when tensions have accumulated over a period of years without sufficient rewards in the sense of having his own dependency needs met and, second, when his capacity to cope with stress is, for some reason, markedly reduced. This latter factor is most likely to come into the life of the successful male some time between the mid-40’s and mid-50’s, when the physical aspects of the aging process are becoming hard to ignore and when the reality of the impossibility of ever doing anything differently—of ever starting over, in other words—becomes hard to avoid.

At about the same age period changes are likely to occur in his life situation that reduce gratification, intensify pressures, and remove supports that have made past productivity possible. His wife has probably reached menopause and, because of the emotional and physiological problems attendant to this stage, she may be less able to give him the attention and closeness he so badly needs. Even when menopausal problems are minimal or nonexistent she can, because of her own growing freedom from child-rearing, divert more of her time and attention to activities outside the home. He tends to view this change, no matter how small, as an estrangement because of his unconscious hypersensitivity to a decrement in these supplies.

Additionally, during this period his children have probably grown into late adolescence and have become less attentive to him, openly unappreciative of his counsel, and pointedly critical of the family’s material position. These occurrences appear to deprive him of the filial love and affection that he perceives as his just reward and which have previously helped to satisfy his dependency needs.

Likely co-acting with these domestic factors are increasing pressures from his work. He is likely to have been promoted to a position of responsibility that he no longer carries easily or to a supervisory

role which exposes him to the dependency needs of his subordinates—and to their anger if those needs are not satisfied. Conversely, he may come to realize that the goals which have sustained him (e.g., the long sought-for promotion) are no longer available or within his reach.

It seems obvious that some of the same factors operate in the meal-ticket syndrome in men that characterize the involuntional depression in women—a feeling of being over the hill, no longer in the prime of life—but usually the meal-ticket syndrome does not contain that element so characteristic of menopausal melancholia in women—a feeling of worthlessness and self-accusation. Rather, in the meal-ticket syndrome, we see anger at feeling trapped in a situation which no longer seems sufficiently worth the effort.

I have mentioned depression and it seems wise to say a little about why we should not regard all such cases simply as depressions and use routinely those treatment methods—antidepressant drugs and electroconvulsive therapy particularly—that work so well in such illnesses. The meal-ticket syndrome contains depression, to be sure, and if the guilt aspects—self-accusation, feelings of unworthiness, suicidal ideas—are prominent, it may well be that making the diagnosis of depressive disorder and treating it accordingly would be perfectly valid. But the guilt aspects in this syndrome are usually overshadowed by the unmet dependency needs, and then disappointment and anger are the most basic feelings, and traditional methods of treating depressions are unlikely to work. Interestingly, relieving the person of his responsibility is not likely to work either. Sending the patient on a vacation, for example, is likely to backfire because he cannot let himself enjoy it and will probably worry constantly until he gets back to work, only to be back in the same vicious cycle as before.

Therapy • What is likely to help is a sympathetic ear. Just listening to a person is one way of meeting some of his dependency needs, and often this is enough to make it possible for him to carry on more comfortably and effectively. Often the patient wants nothing more than this, especially after he finds that this alone can help, although when he first comes he may tend to demand “instant relief.” Such demands often take the form of a plea for drugs and although the psychotropic agents are a boon to modern medicine, it is well to prescribe them carefully in order to avoid transferring the patient’s dependency to them.

Ideally, perhaps, we should try to help such a patient find a more rewarding way of life. Since much of his problem derives from a feeling that he is being used by his family only as a meal ticket, it would seem that anything we can do to make him

feel less so might result in symptomatic improvement. One of the things we can do is talk with his wife. Psychiatrists were once castigated for their traditional reluctance to talk with the families of their patients, but times have changed somewhat and no longer is it regarded as contraindicated to bring the family into the therapeutic process. In the meal-ticket syndrome especially, the physician may be able to help the patient's wife see what is happening and help her accept such feelings as essentially natural and "normal" ones, especially in successful, responsible, and apparently self-sufficient men. In counseling such a wife, it is important to avoid lecturing or scolding her. If she feels accused of failing her own responsibility she may be totally incapable of following the physician's advice no matter how well-founded it may be. If, on the other hand, she can be helped to see how important she is to her husband in sustaining him, in making him feel loved and cared for and appreciated, and if she sees that she will be the gainer as well, she can be a most important ally in the treatment process.

In describing the patient's feelings of disappointment at being, in his view, unappreciated, I want to be sure that I do not leave the impression that I am pointing the finger of blame at the patient's wife. Not infrequently because of such a family's position in the community, the wife does indeed suffer from the same over-commitment of her time and energy that her husband does. On the other hand, his feelings may in no way indicate an actual lack of attention or appreciation on the part of his family. His wife and children may indeed feel

deeply appreciative but this fails somehow to get through to him, and his feelings are the same as though no appreciation existed at all. What I am saying, then, is that his symptoms can be considered truly neurotic.

Luckily, the prognosis in most cases is good. Although the patient has had a predisposition all along toward developing such symptoms, he has also through his lifetime developed many ways of preventing them from occurring. Rather than being weak or inadequate, such patients really have many strengths and competences. They are neurotic, yes, but for the greater part of their lives they have never allowed that part of themselves to take over. Only when the cumulative stresses of a productive and striving life have become so great, and the rewards for facing them—relatively, at least—so small, that they can no longer be handled by their usual techniques of coping with stress do such men begin to break down. And precisely because they have been responsible and productive people, these patients deserve every effort we can make to help them.

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Depression: diagnosis and treatment

A guide for the primary care physician

Astrid M. Dublis, M.D., and Robert A. Dublis, M.D.

ABSTRACT: *Depression is one of the most prevalent of psychiatric illnesses and should be considered by the primary physician in his differential diagnosis even when presenting symptoms would suggest other physical disorders. Depression is a serious illness with considerable morbidity and even mortality and should be diagnosed early, treated actively and with sufficient duration in the course of treatment. Antidepressant medications have been shown to be particularly effective in the treatment of depression but they vary greatly in their effectiveness in individual patients and in their side effect profile. The side effects of antidepressants are primary considerations in the choice of the most appropriate agent and most especially the anticholinergic and cardiovascular effects. The new agents, such as amoxapine and maprotiline, are particularly advantageous in regard to a reduction of these side effects with the maintenance of therapeutic benefit. In order to provide successful treatment, adequate dosage of medication during the acute phase of the illness and the continuation of maintenance medication for a sufficient period of time is necessary. The primary physician must also recognize that when conventional treatment is not effective or when the subsequent development of psychotic or suicidal manifestations does occur, psychiatric consultation should be considered.*

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Depression is among the most common of psychiatric ailments with an estimated 10% to 20% of all adults experiencing an episode at some time during their lives. As many as 10 to 12 million people experience a depressive episode in any given year.

Depressive illness may manifest itself in relatively mild, brief episodes or in mood disturbances severe enough to impair productivity and happiness. A variety of destructive life-style patterns, such as alcohol abuse and marital dysfunction, frequently emerge in the presence of depressive illness. Furthermore, the potential for suicide is considerable in individuals who are severely and persistently depressed. Depression also tends to be a recurring disorder: the number of depressive episodes during each period of vulnerability adds up to a high number in the course of that person's life.

Symptoms • The symptoms of depression fall along a continuum. For example, sadness in response to some real personal loss (e.g., death of a loved one) would be at the milder end of the continuum, whereas the sudden onset of depression for no apparent reason, which is accompanied by hopelessness and thoughts of suicide, would be at the severe end.¹ Most individuals who seek treatment for depression present with symptoms more extensive than simple sadness. They may have already contemplated suicide or perhaps even made a suicide attempt before consulting a physician.

It is of the utmost importance to specifically question a patient who is suspected of being depressed about suicidal thoughts, attempts, or plans during the interview. Contrary to popular opinion, such questioning does not enhance the risk of self-destructive behavior, but indeed may reduce it by offering the patient an opportunity to discuss such thoughts and feelings frankly with the physician.

Two major categories of depression were historically conceptualized. These were the "en-

ogenous," defined as a more biological and autonomous type of depression, and "reactive," defined as a more neurotic, psychological or stress-induced kind of depression. Current thinking does not support such a dichotomous approach, since stress is associated with both types of depression and causes physiologic changes which reflect a disequilibrium of the central nervous system. The endogenous distinction based on lack of precipitating stress has been challenged by the demonstration that many depressions considered "endogenous" were preceded by stress.² Therefore, recent diagnostic systems^{3,4} have avoided this terminology.

Diagnosis • Two diagnostic systems widely recognized in the past two decades, the primary-secondary,^{5,6} and unipolar-bipolar distinctions, are both diagnoses of exclusion with respect to the depressive syndrome. The unipolar-bipolar distinction depends on a history of mania rather than the character of the depressive syndrome. Primary affective disorder is diagnosed when no preexisting nonaffective psychiatric illness is present. Symptomatology was not considered useful for making the primary-secondary distinction. Thus, while symptom criteria were provided, symptoms were less specific than the past history of illness in defining that entity. Although both of these diagnostic systems introduced an important distinction, they are of limited value for defining the symptoms characteristic of major depressive illness.

Other investigators have suggested that the concept of endogenous depression implies more than a lack of precipitant and is useful for defining the character of major depressive illness. One current concept⁷ is that endogenous depression is characterized by typical symptoms and signs, a relatively stable premorbid personality, a course unaffected by environmental events, and an onset that may be unassociated with a psychological precipitant. It has been suggested⁸ that it is the morphology of endogenous depression which characterizes the syndrome and the term "endogenomorphic" has been introduced for descriptive clarity. Endogenous depression has also been associated with an altered physiologic state.⁹⁻¹² It has been suggested that the description of altered physiologic mechanisms¹³ would be useful in establishing the diagnostic validity of the depressive state. Endogenous depression has also been assumed to have a specific relationship to treatment, either pharmacotherapy¹⁴⁻¹⁷ or ECT.¹⁸⁻²¹ Thus, there exists in the literature a concept of major depressive illness characterized by a depressive syndrome unaffected by environmental changes, associated with alterations in neurochemistry and requiring biological treatment. The terms "endogenous," "psychotic," and "en-

dogenomorphic" have been used to refer to this entity. The term "autonomous depression"²² has been suggested as being the most descriptive.

Surveys of medically ill patients have consistently demonstrated that as many as one in eight outpatients and one in four inpatients are depressed. But as many as half of these are undiagnosed by their treating physicians.^{5,7,23,24} Over the course of a year almost 50% of patients with chronic physical illness experience at least one episode of depression.^{8,25} It has also been demonstrated that many different medical conditions can induce depression perhaps through direct or indirect effects on central nervous system neurotransmitter function. The following are the most common categories, grouped in order of frequency:^{12,13,26,27}

- a. Cardiovascular Disease
- b. Endocrine, Nutritional, and Metabolic Disorders
- c. Neurological Disorders Affecting the Central Nervous System
- d. Pulmonary Disease
- e. Infections
- f. Malignancies
- g. Hematological Problems
- h. Drug Reactions

The depressed patient is likely to visit the primary care physician for an initial evaluation whether he is physically ill or not. The diagnosis may be difficult unless the physician specifically considers depression since the depression is frequently masked by complaints such as back pain, chest tightness, gastrointestinal discomfort, or headache. Every primary care physician sees a great number of depressed patients: it is one of the leading reasons for patients coming to the physician's office. At times patients specifically state that they have been feeling depressed and request treatment for this condition although what the patient means by depression will have to be determined. Other patients come to a physician's office, often repeatedly, with a variety of somatic complaints for which no organic basis can be found. However, instead of being an exercise in frustration and futility, this can assist the alert physician in establishing the depressive diagnosis and the diagnosis that is amenable to treatment.

Careful inquiry must be made into the etiology of the depression. Is it secondary to an underlying medical problem such as the ones previously described?²⁸ Is the depression secondary to another psychiatric problem such as schizophrenia? If the physician sees evidence of hallucinations or delusions, he might consider psychiatric consultation. The physician also must take a thorough history of the present illness including the patient's activity,

behavior, and sleep patterns; past medical history and family history, particularly since it has been demonstrated that depressive illness has a genetic component. In addition, a thorough physical examination should be made. Once depression has been diagnosed, treatment can be initiated.

Treatment • Two different types of errors may occur in the treatment of the depressed patient. One is that the depression is not diagnosed and the other is that the depression is diagnosed but not properly treated. The first type may be made if the primary physician is unfamiliar with the presentation of depression or the atypicality of its presentation. The second can have various origins. The physician may not appreciate the significant morbidity and subjective distress that the depressed patient experiences. The physician may believe that treatment will not necessarily change the outcome of a depression, or that a depression is a time limited illness and therefore no treatment is necessary. Such approaches may be caused by unfamiliarity with the pharmacological and psychological management of depression. However, since the action the physician takes will impact on the course of the depression and will alleviate the patient's suffering, it would be beneficial for the primary physician to become adept in the diagnosis and treatment of depression.

The nature and severity of depressive illness will determine its treatment. In the early days of antidepressant chemotherapy, it was commonly taught that only the more severe forms of depression, particularly those with psychotic features, should be treated pharmacologically. Psychotherapy was often suggested as the preferred form of treatment for the milder forms of depression. However, our modern knowledge of antidepressant medications has changed that concept.²⁹ This is not meant to imply that every individual who becomes mildly depressed following a personal loss should receive antidepressant chemotherapy. On the other hand, it would be equally wrong to delay pharmacologic treatment until an individual becomes so severely immobilized by depression that he cannot work or enjoy his leisure-time activities. It is even worse for an individual whose depression is being treated non-pharmacologically to experience a suicide attempt before receiving definitive medical management.

The management of depression should be approached in the same manner as the management of other medical syndromes such as congestive heart failure or hypertension. The initial goal is to provide symptom relief while the long term goal is to search for the underlying pathophysiology and psychopathology. Although depressed patients may have similar or identical signs and symptoms, the etiology of the depressions may differ. For example, a patient may develop depression as a result of a

physiological contributor such as hypothyroidism or the central nervous system pharmacological action of an antihypertensive medication.^{14,15,30} Another patient may have a genetic vulnerability which, combined with certain psychosocial stresses, results in depression.

The most specific treatment for the patient who has experienced the physiological symptoms of depression for two or more weeks is the use of an antidepressant drug. It is becoming increasingly clear that the physiological symptoms of depression probably result from a CNS dysequilibrium state in the limbic-hypothalamic-pituitary axis.^{14,18,31} It has been demonstrated that two important neurotransmitter systems are altered in many depressions: norepinephrine and serotonin. Recently, it has been shown that alterations in alpha and beta adrenergic receptor function also may play a role in the etiology of some depressions.^{19,20,32,33} Even more exciting is the fact that certain antidepressants may correct these alterations.

Clinical lore suggests that agitated or anxious patients respond better to relatively sedating tricyclics, such as amitriptyline or doxepin. Conversely, patients with a retarded depression are believed to do better on a drug with somewhat less sedative action, such as imipramine, or one with an "activating" effect such as protriptyline. However, this belief has not been evaluated systematically. It may be valid with regard to initial symptom relief but not to ultimate antidepressant response. In this regard, psychomotor retardation has been reported to predict response to both amitriptyline and imipramine (and, presumably, to other tricyclic antidepressants).³⁴ Poor appetite, weight loss, middle insomnia, and early morning awakening have also been reported to predict response to tricyclic antidepressants.

Since these are symptoms of an "endogenous" or "endogenomorphic"⁸ syndrome, it is not surprising that a good response to tricyclic antidepressants has been found in patients with this syndrome.^{35,36} It has been suggested³⁷ but not confirmed that patients with unipolar endogenous depression may be more likely to respond to tricyclic antidepressants than those with a bipolar illness.

According to current general thinking the tricyclic antidepressants work by increasing available norepinephrine or serotonin by preventing presynaptic re-uptake.³⁸ Thus, the choice of an antidepressant agent basically has two considerations: (1) which system is it more important to impact on, and (2) what side effects are desired or important to avoid. Regarding the first consideration, some, but not all, psychiatrists believe that there are adrenergic versus serotonergic types of depression. In those patients who are "low in norepinephrine," an agent such as nortriptyline, desipramine or

maprotiline is selected. For depressions in which serotonin deficit is primary, an agent such as amitriptyline may be employed.³⁹ The clinical basis for the distinction is generally that agitated depressions are treated with serotonergic agents such as amitriptyline, whereas retarded depressions are treated with norepinephrinergic agents such as maprotiline.

Drug Selection • Some psychiatrists do not subscribe to this "two kinds of depression" theory at all and thus believe this distinction is completely arbitrary and should not be the basis of drug selection. A history of a patient responding to a particular medication when depressed in the past or even a family history of response to a given medication may be a strong reason to use that agent again.⁴⁰ In general, all FDA approved antidepressant medications are about equally efficacious and therefore an important consideration is side effect profiles.³⁸

All antidepressants have varying degrees of anticholinergic and sedating side effects: peripheral anticholinergic effects include dry mouth, blurred vision, constipation, difficulty urinating, and tachycardia. Central anticholinergic effects, such as memory impairment and inability to concentrate, are also not unusual in untreated depressed patients.^{31,41} Patients who are especially sensitive to cholinergic blockade, such as the elderly, individuals with organic brain dysfunction, or those already taking anticholinergic agents, may become confused, disoriented, and overtly psychotic when a high dose of a potent anticholinergic is added to their treatment regimen.⁴² Although there is a great deal of interpatient variability,^{26,28,43-45} for such patients prudence dictates the use of an antidepressant which is relatively low in anticholinergic activity, such as desipramine or maprotiline. These drugs are also more useful in patients with open-angle glaucoma, prostatic hypertrophy, or serious problems with constipation.

Sedation is another pharmacological parameter by which the antidepressants can be differentiated from each other. Degree of sedation seems to be equivalent to potency of CNS antihistaminic activity.⁴³ If insomnia is an especially prevalent symptom, the more sedating drugs, such as doxepin or maprotiline may be useful. If both sedation and low anticholinergic side effects are desired, maprotiline may be the drug of choice. In addition, maprotiline seems to have a preferential therapeutic effect for agitated depressives.

One of the most controversial aspects of antidepressants is their cardiovascular effects. In patients without cardiovascular disease, antidepressants are essentially free of serious adverse effects.^{29,46} Nevertheless, these medicines do have quinidine-like properties and overdoses can create arrhythmias

similar to those of quinidine.^{29,32,46,47} The most common potentially serious cardiovascular complication of antidepressants is orthostatic hypotension which is thought to be related to peripheral alpha-adrenergic blockade.^{29,46} Nortriptyline has been reported to be less problematic in this regard. However, when used at low doses (50-75 mg per day), maprotiline, amoxapine and doxepin may be less likely to produce significant hypotension as compared to imipramine and amitriptyline.^{29,30,42,46,48}

The fact that antidepressants can prolong the P-R interval and the QRS complex must be considered in patients with abnormalities of intraventricular conduction since there is a risk of precipitating heart block in such patients.^{29,46} Despite some controversy, a number of studies have demonstrated that patients with ischemic heart disease, but not in overt congestive heart failure, can be safely managed on low doses (50-100 mg per day) of most antidepressants.^{29,41,46,49} Although well controlled, dose-comparative studies with all other antidepressants either have not been done or have not shown significant differences in side effects, doxepin and maprotiline are often said to be safer for patients with cardiovascular disease.^{29,40,41,46}

Generally, treatment with antidepressants is initiated by prescribing a divided dosage, such as doxepin or maprotiline 25 mg PO TID. If side effects are not problematic, 25 mg may be added to the dosage every 2 days until a total dose of 150 mg is reached. After approximately one week of therapy the antidepressant may be given entirely HS. Dosages above this level, often as high as 300 mg per day, are not unknown and are often employed by psychiatrists. However, if this becomes necessary, consultation may be needed as issues such as serum levels become a consideration. Even at the same dose, serum level of different patients varies tremendously. Clinical efficacy seems to relate to serum level and with some antidepressants there may be a phenomenon known as "a therapeutic window"—that is, serum level must neither be too high nor too low.⁴⁹

The most common antidepressant prescription errors are failure to utilize adequate dosages, failure to continue treatment long enough, and failure to advise the patient about side effects and adjust dosage or change to another agent to increase compliance.

The first symptoms usually relieved by adequate antidepressant drug treatment are sleep disturbance, agitation, and frequency of crying spells. Actual mood elevation may not occur for 3-4 weeks and the patient should be warned of this delay to avoid further feelings of hopelessness and possible intensification of suicidal thoughts.

Premature discontinuation of antidepressant therapy may lead to relapse of symptoms. In a patient with no personal or family history of depression, a 3-6 month course of treatment may be adequate. A patient with a previous episode of depression should be treated with a 6-12 month course of antidepressant therapy.⁴² In both instances, cautious tapering of dosage (25-50 mg per week) can help identify early signs of relapse and avoid any withdrawal effects (e.g., nausea, headache) that can occur when the medication is abruptly withdrawn.

Summary • Depression is a common illness which the primary physician should consider in his differential diagnosis, even when presenting symptoms suggest other somatic disorders. Depression should not be considered as time-limited: it is an illness with considerable morbidity and occasional mortality which should not remain untreated. Antidepressant medications are effective in the treatment of depression and the selection of a particular agent will depend on its side effect profile or history of prior patient response. Side effects, especially anticholinergic and cardiovascular effects, are primary considerations in the choice of a specific antidepressant. The newer agents such as amoxapine and maprotiline are particularly advantageous in this regard. To ensure the successful treatment of the depressive illness, adequate dosage of medication and the continuation of maintenance medication for a sufficient period of time is essential. In the event the patient does not respond to conventional treatment or appears to become psychotic or suicidal, psychiatric consultation should be sought.

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A prototype antibiotic audit form for community hospitals

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ABSTRACT: *Ongoing antibiotic audits are required by most general hospitals. A practical form used for such an audit is presented, along with the manner in which it was utilized at two community hospitals. Other institutions can readily modify this prototype.*

Serial audits uncovered several common deficiencies. This led to pertinent constructive efforts for improving inpatient antibiotic therapy. They included appropriate continuing education for the entire medical staff, the monitoring of antibiotic use and sensitivities, and related activities by appropriate committees and nurse-epidemiologists.

The Pharmacy and Therapeutics Committees and Antibiotic Utilization Committees of community hospitals can play a major role in the upgrading of antibiotic therapy.

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About one third of patients in general hospitals receive antimicrobial drugs.¹ The figure rises to 60% on some surgical services. An estimated 70% of the antibiotics so used are expensive aminoglycosides and newer "generations" of cephalosporins or penicillins.²

Physicians have a wide latitude of choice in selecting antibiotics. Their differences in prescribing reflect the influence of teachers, medical journalism, local customs, consideration of cost, and other variables. For example, clinical judgment may be affected by laboratory printouts designed to select antibiotic sensitivities.³

Unfortunately, most institutions conducting careful antibiotic audits have found severe deficiencies. Half or more of the patients so reviewed had received antibiotics that were either not indicated or given in a manner subject to criticisms. They included shortcomings pertaining to the selection of these drugs, the dosages administered, and monitoring for potentially serious side effects. Comparable deficiencies have been encountered both in teaching centers and community hospitals.^{1, 5, 10}

The need for antibiotic accountability prompted requests for ongoing antibiotic audits by the Joint Commission on the Accreditation of Hospitals. Some published audit reports underscore these problems.

1. A retrospective analysis of 50 randomly selected patients receiving antibiotics at the Duke University Medical Center in June 1973 revealed major deficiencies in 64%.⁵
2. Antibiotic usage was evaluated in a large pediatric teaching hospital during a three-month period.⁹ The audit indicated that antibiotic administration had not been appropriate in 66% of surgical patients and 21% of medical patients. Failure to obtain pertinent studies prior to and during such treatment was a common infraction on all services. Frequently, surgical prophylaxis was not indicated, was prescribed in incorrect dosage and timing, or given as an inappropriate drug.

3. A review of the prophylactic use of antimicrobial drugs in 20 general Pennsylvania hospitals, involving 5,288 charts, revealed that almost 80% had been administered 48 hours or longer.¹

Evolution of a prototype audit form ● The Pharmacy and Therapeutics Committees of the Good Samaritan Hospital and St. Mary's Hospital in West Palm Beach were requested to conduct antibiotic audits by their respective Executive Committees. Both institutions have more than 300 beds and can be regarded as representative of good community hospitals. They are approved by the Joint Commission on the Accreditation of Hospitals. The majority of their staff members are board certified or board eligible for specialty certification. Both hospitals require annual verification of postgraduate medical education. They also have nurse-epidemiologists and infection control committees.

From the outset, it was evident that an audit of every antibiotic prescribed at both hospitals would be difficult. Accordingly, it was decided to focus upon those antibiotics having frequent or serious side effects on the liver, kidneys, bone marrow and gastrointestinal tract. They included chloramphenicol, gentamicin, tobramycin, kanamycin, streptomycin, parenteral sodium colistimethate, intravenous carbenicillin, oral clindamycin, and oral lincomycin.

A search for practical guidelines and a prototype when the audits were begun (1975) proved unproductive. In devising an appropriate audit form, the Committee believed that the following components were necessary:

- Pertinent general data concerning the patients.
- Verification of the diagnosis for which the antibiotic under audit had been administered, or the condition for which prophylaxis was deemed necessary.
- Verification of the existence or probability of the infection treated, with emphasis upon adequate cultures.
- Inclusion of the audited antibiotic(s) in the final summary.
- An opinion by the reviewer as to whether the antibiotic was indicated on clinical or laboratory grounds—recognizing certain potential fallibilities. Examples include the usual ineffectiveness of gentamicin in staphylococcal infections (notwithstanding *in vitro* sensitivity of the organism), and the limitations of oral carbenicillin in nonrenal *Pseudomonas* infections.
- An opinion as to whether the antibiotic had been given in proper dosage and for an adequate period on the basis of pertinent clinical considerations (e.g., renal and liver function).
- An opinion as to whether clinical and laboratory monitoring—in terms of potential side effects—was adequate.
- An opinion as to whether the chart warranted further review by the Committee due to serious deficiencies (e.g., failure to obtain a blood count after chloramphenicol or renal studies after gentamicin).

After several revisions and trial audits, the form in Table 1 was adopted.

Conduct of the audit ● An attempt was made to obtain useful data with minimal imposition upon personnel and facilities. Accordingly, the antibiotic audit was conducted in the following sequential manner.

Every physician-member of the Pharmacy and Therapeutics Committee was responsible for auditing a comparable number of charts within a specified period of time. They were distributed by the medical records department.

It was recognized that these physicians represented various specialties—and therefore might not be conversant with the management of complex problems in other fields. A double audit was therefore performed by the chairman (a board-certified internist) reviewing every chart and audit form.

The selection of charts was unbiased. It originated from consecutive requests for the antibiotics under audit at the pharmacy, which then relayed this information to the Medical Records Librarian. After the patient's chart had been completed by her department, it was sent to a physician-member of the Committee for audit.

Since the audit was being done for informational purposes only, the Committee sought to give attending physicians the benefit of any reasonable doubt. Finley⁴ emphasized the potential injustice of reviewers concluding that antibiotic therapy was "inappropriate" or "not indicated." Consultation from other physicians was obtained whenever a significant doubt arose. An example was the matter of the purported infrequent ototoxicity and nephrotoxicity of kanamycin when given to infants.⁹

The Committee believed that information on at least 50 patients would be required to establish trends. A retrospective analysis of antibiotic use at the Duke University Medical Center also was based on 50 randomly selected patients.⁵

Following completion of the double-audit, the data were reviewed by the chairman and the nurse-epidemiologist who then tabulated them. They were listed next to the preceding years' results in the final tabulation sheets.

ANTIBIOTIC AUDIT			
Patient _____ Hospital # _____			
Nature of Infection (Auditor to fill in) _____			
Antibiotic(s) under review (Please check one or more as applicable)			
<input type="checkbox"/> Chloramphenicol (Chloromycetin) <input type="checkbox"/> Gentamicin (Garamycin) <input type="checkbox"/> Kanamycin (Kantrex) <input type="checkbox"/> Streptomycin <input type="checkbox"/> I.V. Carbenicillin <input type="checkbox"/> Oral Cleocin <input type="checkbox"/> Oral Lincocin <input type="checkbox"/> Coly-Mycin <input type="checkbox"/> Tobramycin (Nebcin)			
Physician Reviewer _____			
(1) Was the above antibiotic, alone or in combination, indicated on the basis of the following?		Circle	
(a) Clinical judgment		Yes	No
(b) Culture and sensitivity studies		Yes	No
(2) Is the diagnosis of the infection correctly listed on the front (blue) sheet?		Yes	No
(3) Did the dosage appear to be proper, based on such considerations as severity of the infection, patient age, blood count, renal and liver function, and other factors?		Yes	No
(4) What is your assessment of the duration of antibiotic therapy administered?		About right _____ Insufficient _____ Too long _____	
(5) Were the necessary cultures taken?		Yes	No
(6) Was the underlying infectious organism (or organisms) listed on the blue (front summary) sheet?		Yes	No
(7) Was the antibiotic properly renewed after 3 days?		Yes	No
(8) Was use of the antibiotic being audited included in the final summary?		Yes	No
(9) Were the customary side effects and adverse reactions anticipated in terms of the following?			
(a) Clinical evaluation (such as hearing loss)		Yes	No
(b) Appropriate testing (blood count, urinalysis, BUN, liver studies, etc.)		Yes	No
(10) If gentamicin (Garamycin) is the drug being audited, was at least one blood level done during the course of therapy?		Yes	No
(11) Were significant allergic reactions or side effects properly noted in the following places?			
(a) Progress notes		Yes	No
(b) Final summary		Yes	No
(12) If the antibiotic was given as prophylaxis, was it discontinued after 48 hours?		Yes	No
(13) Do you believe that the manner of antibiotic usage in this patient warrants further review by the Committee?		Yes	No
(14) Please indicate any additional information you would require from the attending physician in order to fully evaluate the chart as presented to you.		_____ _____ _____ _____	

Table 1. — Form used for antibiotic audits.

The results were presented to the Executive Committee along with a written summary of the essential findings. This information then was circulated to all members of the Medical Staff. An attached statement from the Chairman of the Pharmacy and Therapeutics Committee noted that the raw data were available for review by any interested physician, and comments or constructive suggestions that might improve antibiotic therapy at the hospital were welcome.

Results • The findings of these audits confirmed many of the shortcomings pertaining to antibiotic therapy encountered by other institutions. Many were minor (e.g., omissions in the final summary or front summary sheet). Those of more concern pertained to (1) failure to obtain adequate cultures, (2)

inappropriate choice or continuation of antibiotics on the basis of culture and sensitivity studies, (3) failure to monitor renal function in patients receiving aminoglycosides, (4) administration of a "prophylactic" antibiotic for three days or longer, and (5) other deficiencies in both the clinical and laboratory monitoring of antibiotic therapy.

Audit-initiated actions • The foregoing experience led to constructive joint efforts by the medical staffs and administrators of both hospitals to improve inpatient antibiotic therapy.

Formal seminars on the proper use of antibiotics were sponsored. They included audiovisual programs and invitational lectures by infectious disease authorities. Interested health professionals in the

community were invited and continuing education credits offered. In a sense, such activities provided an "educational barrier" between "detail men" promoting antibiotics and the practicing physician.

It has been the experience of other institutions that inappropriate antibiotic usage continues at the same level without adequate in-house education and clear guidelines.⁹ A case in point is the administration of tetracycline or nitrofurantoin to patients with renal insufficiency. Counts¹⁰ commented: "If misuse of antibiotics is found, teaching on a departmental level is, in my opinion, the corrective measure that constitutes the most desirable antibiotic control mechanism."

An ongoing analysis of the frequency of bacterial isolates has been maintained. This was coupled with notification of changes in antibiotic sensitivity patterns ("antibiograms").

The vigilance by nurse-epidemiologists and infection committees of both hospitals increased. It may be desirable for every staff physician to serve at least one term on a hospital committee charged with evaluating antibiotic utilization.

Appropriate information and reminders were issued at staff meetings. They included emphasis upon the use of narrow-spectrum antibiotics whenever possible, and restraint in ordering certain antibiotics to minimize the emergence of bacterial resistance.

Both hospitals participated in the South Florida Hospital Consortium for Infection Control.

Annual antibiotic audits were instituted to ascertain changes in antibiotic use. Recommendations were made to include the newer "generations" of cephalosporins and penicillins, and combining audits with valid algorithms for the reproducible assessment of adverse drug reactions (ADRs).¹¹ The risk of ADRs with antimicrobial agents ranges up to 8.5%, more than half being moderate or severe.¹²

Ongoing discussions by the Infection Committee and the Pharmacy and Therapeutics Committee were initiated relative to the judicious limitation of antibiotic use. Such action reflected concern over prescribing errors.¹⁰ One suggestion was a simple form to be placed on the charts of patients receiving potent antibiotics for three or more days that requested the physician to indicate whether continued antibiotic therapy is indicated. This could dovetail with existing hospital policies requiring the renewal of an antibiotic order after 72 hours. Kunin² criticized the practice of prescribing antibiotic prophylaxis without a time limit.

There was a reevaluation of antimicrobial prophylaxis relative to surgery along "The Medical Letter" guidelines.^{13,14} Such prophylaxis must be tailored to the nature of potential pathogens (as Gram-negative enteric bacteria in operations involving the bowel or the female genital tract, and possi-

ble penicillinase-resistant staphylococci in cardiovascular and orthopedic surgery.² An added consideration is the extraordinary cost incurred by prolonged prophylactic antibiotic administration, that is, beyond 48 hours.¹

Comment • There is a need for ongoing educational programs aimed at the proper and cost-effective use of antibiotics as physicians are barraged by promotional campaigns for newer products. Such education must emphasize the arbitrary use of expensive "second generation," "third generation," and even "fourth generation" cephalosporins and penicillins when they offer few true advantages over existing antibiotics. These observations are germane.

Proper-dosage regimens approximate \$7/day for "first generation," \$37-43/day for "second generation," and \$62-73/day for "third generation" (moxalactam, cefotaxime) cephalosporins.

Cefaclor (Ceclor) is promoted as having greater microbiologic activity against both ampicillin-sensitive and ampicillin-resistant isolates of *Hemophilus influenza* than other "first generation" cephalosporins. In reality, this constitutes an infrequent problem for adults with community-acquired infections.

"Second generation" products (cefamandole, cefoxitin) allegedly have more activity against some aerobic Gram-negative bacteria (*Enterobacter*, indole-positive *Proteus* species, *Citrobacter*). Since these infections are usually acquired in a hospital setting, they are not a major problem for outpatients.

"Third generation" cephalosporins may be less active against *Staphylococcus aureus* and *S. epidermidis*, other Gram-positive organisms, and *Bacteroides*. Moreover, their use risks certain complications (bleeding, resistant strains, superinfections, an antabuse-like reaction to alcohol). I have encountered serious Enterococcal superinfections when moxalactam was employed as a routine postoperative antibiotic. This complication also has been encountered by others.¹⁵

Teaching programs must point out the dubious data on which some promotional efforts are founded. For example, some "second generation" cephalosporins are widely prescribed by orthopedic surgeons in hip replacement surgery who predicate such use upon improperly-interpreted (and unconfirmed) information about bone concentrations.

Antibiotic audits by Pharmacy and Therapeutics Committees can document improper trends in selecting antibiotics that invite bacterial resistance especially in the case of the three major aminoglycosides. They should urge selectivity in

their deployment (especially amikacin), and discourage the simultaneous use of two beta-lactam antibiotics. Failure to do so could have dire consequences (e.g., the closing of entire floors or wings wherein patients contracted infections caused by resistant organisms).

Antibiotic evaluation committees ought to focus on measures aimed at upgrading antibiotic therapy in their hospitals.

Physicians should document why they are prescribing an antibiotic.

"Therapeutic trails" of antibiotics in unexplained fever should be discouraged. Experience indicates that up to one third of hospital-acquired fevers are not due to infection.

Antibiotic orders should be automatically terminated after 72 hours if not renewed by a physician.

"Prophylactic" antibiotic usage for surgery is best limited to three doses of an appropriate drug. (The first dose should be given shortly before surgery.)

New staff physicians should be provided with a hospital's policy concerning the recommended use of antibiotics. They also must be encouraged to avail themselves of an appropriate consultant when confronted with protracted fever and related problems.

The Lancet properly summed the role of antibiotic audits in these terms:

Audit should by no means be regarded as a policing exercise, or imply a threat to the clinician's freedom to prescribe as he thinks best. Rather it should serve as a reminder of the need to justify selection of antimicrobials in the light of critical analysis.¹⁶

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Workers' Compensation 1982

James F. Richards, M.D.

The ancient history of Workers' Compensation in the State of Florida is well known to members of the Florida Medical Association because of the many editorials, articles and paragraphs written over the past eight years.

In 1975, after two public hearings, FMA's lawsuit filed against the Bureau of Workman's Compensation and a third public hearing, we were granted a 32% across the board increase. This increase did not address the inequities among various parts of medicine, i.e. surgery, medicine, anesthesia, pathology and radiology; but it perpetuated those inequities bringing some areas closer to what the doctors might consider a fair fee than other areas. Particularly low were surgery, medicine (meaning office visits and hospital visits, etc.), and anesthesiology.

After the Division of Workers' Compensation (the old Bureau of Workmen's Compensation) failed to deliver on their promise to upgrade the fee schedule annually, FMA in 1979, using the same tools that the Division had used earlier to arrive at 32%, i.e. the Consumer Price Index, succeeded in a 35% increase across the board. Again, FMA argued that the fee schedule paid some disciplines more poorly than others. The FMA also argued in 1975 and again in 1979 that the state should address the question of paying a higher fee schedule to certain geographical areas of the State. Specifically, the original area in question was Dade County and more currently, Broward, Monroe and Palm Beach Counties have been added.

Now for more recent history. Public hearings in the Fall of 1981 and Winter of 1982 culminated in April 1982 with the Division granting the doctors of Florida a new fee schedule no longer increased across the board, but based on a percentile. FMA had argued the 75th Percentile and was granted a 66 2/3rd Percentile, which is in dollars and cents not a great deal different; but the percentile was different enough

that the Division did not have to consider raising rates to the various insurance carriers at that increase.

The new fee schedule, based on the 66 2/3rd Percentile of fees currently charged in the state, would raise surgery fees approximately 66%, medicine fees approximately 66%, anesthesiology approximately 31% and have little effect on either pathology or radiology. These were the two areas that had been more adequately paid by the old fee schedules. This increase may represent \$30,000,000 a year to the estimated 4,500 doctors who do Workers' Compensation or \$100,000 a working day.

The FMA also argued in 1975 and again in 1979 that the state should address the question of paying a higher fee schedule to certain geographical areas of the State.

The FMA felt that this was a monumental change in direction and was extremely pleased with the results and the implied promise that it could expect an increase to the 75th Percentile for the year 1983.

As all know, a group of orthopaedic surgeons from Palm Beach filed a petition to block the new rule, and therefore the new fee schedule. This was filed in April 1982 and these same doctors dropped their petition during the summer of 1982. FMA had anticipated the new fee schedule going into effect between June 1 and July 1, 1982, and now has every expectation that it will, indeed, go into effect October 1, 1982, some three or four months late. Better late than never!

It is FMA's understanding, from communication with the doctors involved, that they have every intention of refiling their suit to block the 1983 rule (which hopefully will be the 75th Percentile) and make the courts decide whether and how the Division should pay doctors for care of injured workmen under a usual and customary system.

The Author

JAMES F. RICHARDS JR., M.D.

Dr. Richards is Chairman of the FMA Committee on Workers' Compensation and practices orthopaedic surgery in Orlando.

The Florida Medical Association recognizes that it would certainly be desirable for the doctors of Florida to be paid usual and customary. Apparently this system is done in some states; and this is certainly one of the things that FMA has repeatedly requested of the Division.

If the Division does eventually come around to paying usual and customary fees in the State of Florida, they will, of necessity, have to maintain profiles not only on various areas of the State but on each individual physician who practices any Workers' Compensation.

If the Division does eventually come around to paying usual and customary fees in the State of Florida, it will, of necessity, have to maintain profiles not only on various areas of the State but on each individual physician who practices any Workers' Compensation. This, of course, would be comparable to the Blue Shield Program. As we all know, Blue Shield recognizes several areas of the State where, geographically, economics vary enough that the fee schedule is different. The profiles are kept so that the Blues have a handle on what individual doctors charge, referred to as the doctor's *usual* charge. That charge may be increased from one year to another depending on the doctor's performance, his charges and therefore his profile.

In the same geographic area, all doctors performing a specific service create a *customary* fee based upon the 90th Percentile of all fees. Under the UCR contract of the Blues, the fee paid is the doctor's usual fee or the community customary fee, depending on which is less.

Now the Division has adamantly refused since 1974 to recognize even two areas of the state because it would require keeping profiles on two geographic areas. In the usual and customary plan, the Division must not only maintain geographic statistics, but statistics on each individual physician. That represents a problem for the Division and for the doctors who wish to be adequately paid for their services.

Still another suggestion of doctors in the state has been to pay them on the 90th Percentile. This, of course, would be similar to the UCR Program of the Blues. However, unless the Division is willing to recognize various economic areas of the state, it would be paying highly inflationary fees in certain

areas and underpaying doctors in others. Only if the Division would recognize various economic areas of the state, could payments at the 90th Percentile be feasible.

At the present time, the Florida Medical Association has hired a statistician from Gainesville and, working with the FMA, the Dade County Medical Association has hired a statistician as well. Together, the two organizations have been accumulating data which it is hoped will show that on the basis of both charge patterns and cost of living, certain areas of the state do indeed justify higher fee schedules. Statistics that are required and might be accepted as evidence by the Division cost money and both DCMA and FMA have committed funds to this effort. Palm Beach, Broward and Monroe counties are encouraged to participate and contribute to this effort as much as possible so that when FMA does go to a public hearing in the Fall of 1982 it can have as much valid statistics for evidence as possible. There is no date as yet for such a public hearing, but it is anticipated that it will probably be sometime in October or November.

Only if the Division would recognize various economic areas of the state, could payments at the 90th Percentile be feasible.

Not to belittle what has been accomplished, it should be stated that there are physicians in the State of Florida who would be extremely pleased to be paid under the Workers' Compensation Program at the 75th Percentile, provided that level is corrected annually. It is the author's opinion that the 75th Percentile will be acceptable to many, but not to all, unless the Division comes to grips with the fact that charges and costs are higher in certain counties and is willing to make the 75th Percentile apply to the geographic areas in question. As time progresses, those geographic areas may include more than Dade, Broward, Monroe and Palm Beach counties. Indeed, if and when the Division accepts the responsibility of collecting statistics and determining that one county is deserving of a slightly higher rate of pay than another, they must simultaneously accept the responsibility for an ongoing study to identify counties which may qualify in the future.

- Dr. Richards, 1315 S. Orange Avenue, Suite D, Orlando 32806.

Intervention

A process for helping impaired physicians

Dolores A. Morgan, M.D., and Vernon E. Johnson, D.D.

The process of intervention is a proven successful method of saving the lives of individuals incapable of helping themselves. Whether it is an acute physical crisis such as a heart attack or a chronic life-threatening disease such as substance abuse or addiction to a drug, reaching out to save a life is every physician's responsibility. In the first instance C.P.R. immediately instituted may save the person's life. In the latter the method of intervention differs, but the ultimate result of saving a life can be just as dramatic.

The objectives of this paper are to define the intervention process, identify the principles of intervention, describe the preparation for an intervention and give illustrations of how the intervention process can be carried out to a successful outcome. A physician's knowledge and skill in intervention may assist an impaired colleague to get treatment as early as possible and thus prevent the physical and psychological devastation which can occur with the use of alcohol and other addictive drugs. It can also mean the return of health and happiness to a physician's family who are so adversely affected by his/her drug use.

Physicians are often reluctant to reach out to an impaired colleague. They have been taught to wait for the patient to come to them for assistance; that a person cannot be helped unless he asks for help and that soliciting patients is against medical ethics. They have also been intimidated by threats of legal intervention to the point that they are hesitant to become involved even in assisting their close colleagues. In spite of these reasons some physicians are willing to take whatever risks are necessary to save the lives of their physician colleagues through the intervention process.

Intervention is defined as the presentation of reality through specific data in a caring, concerned

manner. Since the delusional system which develops with the use of drugs precludes the individual asking for assistance, the intervention process may mean the difference between life and death. Mood altering drugs exert a direct effect on the brain which impairs his/her judgment and decision making capability. In addition, the social stigmata which persist relative to drug use strengthens the need to protect oneself with extension of delusional mechanisms. To wait for an individual who has become involved with alcohol and/or other addictive drugs to ask for help is comparable to waiting for a person who is unconscious after a myocardial infarction to ask for help. Every physician recognizes his responsibility to the unconscious person, so must each recognize his responsibility to the drug impaired individual.

To wait for an individual who has become involved with alcohol and/or other addictive drugs to ask for help is comparable to waiting for a person who is unconscious after a myocardial infarction to ask for help.

The principles of intervention include:

1. Selection of meaningful persons.
2. Presentation of specific data.
3. Demonstration of attitude of concern.
4. Presentation of at least two alternatives.
5. Follow through of process.

Preparation • Preparation for an intervention is essential if a successful outcome is anticipated. Before one enters into the process of intervention with a suffering alcoholic or addict of another drug, one should ask a number of questions. The first question should be: "What do I know that makes me believe an intervention should take place?" Any information which reflects a problem in the family, office or hospital may be pertinent. When the hospital is unable to locate a physician repeatedly who is on call; if the office personnel are frequently

The Authors

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needing to change or cancel the physician's schedule because of illness or unknown reason, and when the wife describes episodes of "blackout" on the part of her physician husband, one must believe that a problem exists.

When there is sufficient data from a number of sources to indicate the person is headed for trouble, the second question is: "Who are the most meaningful people in this person's life?" The most meaningful people are not necessarily the most influential, have the most power, or the warmest and closest relationship. They may be meaningful for any one of those reasons or they may be meaningful though there be no particular relationship. For example, in Atlanta, the Salvation Army has found the most meaningful person to get a particular portion of our population into treatment, namely the skid row alcoholics, is the judge. In the case of the physician, it may be his office manager, partner, children or the chief of staff and hospital administrator. At least two people and as many more as may be available, knowledgeable and willing, may be utilized. We have done interventions with as many as eight or nine people.

**One of the most generally
mistaken notions about addiction is
that the individual must wait until he
hits some kind of bottom.**

After having gathered two, three or some number of people listing their agreement to enter into an intervention, the third question is: "Do these people know their task?" You can make no assumptions that because a person is a professional he will know how to approach an addict. Even experts in the field of addiction are sometimes duped. One needs a knowledge of the nature of the addictive diseases just as much as the nature of cardiac diseases. Does the person have enough of a conviction about the treatability of the illness to convince the sick person? One of the most generally mistaken notions about addiction is that the individual must wait until he hits some kind of bottom. There is a mistaken notion that they come to some kind of spontaneous insight that allows them to offer themselves to treatment. Others believe there is nothing that can be done. The attitudes and knowledge of the meaningful persons must be assessed and corrected as necessary to approach the intervention.

The fourth question related to the meaningful persons must be: "What is the emotional condition in terms of the relationship that exists?" "What is the emotional stability of the person?" The individual may care so much as to be immobilized or

incapable of taking even the slightest kind of risk with the present relationship. Wife or husband may believe "If I do that he/she will divorce me." "If I do that, he will never talk to me again" may be the attitude of a colleague. The person organizing the intervention may sense whether or not the meaningful person is capable emotionally of taking this risk. It may be necessary to convince the individual of the progressive nature of the illness with a choice of risks; that is, a risk of the relationship on one hand and the risk of the individual's death on the other.

A fifth question might be: "Is this person capable of showing concern?" The meaningful person may be so full of hostility and resentment that he will only put the sick person more on the defensive and result in a more difficult intervention. Or the individual may talk so much and/or every time he opens his mouth he sounds like a top sergeant. Maybe a top sergeant could be included if he is not permitted to talk too much. The chief emotional setting should be one of concern rather than punitive or accusatory.

Kind of Data Needed • Once individuals are knowledgeable enough, emotionally stable and capable of expressing real concern, they must be advised as to the kind of data needed. Intervenor must be prepared to make a list of specific data and abandon generalities. The data, anecdotal incidents, should be sufficiently explicit to enable the sick person to see himself as he behaves under the influence of chemicals. The sick person is so bound by his delusional memory system that he does not recognize his slurred words, he does not realize he has a staggering gait, his distortion of the truth is not a conscious lie but an unconscious defense mechanism. His perception of reality is grossly distorted by the effects of drugs on the brain cells. The data should be presented first hand and in as specific terms as possible. If the intervenors write their observations prior to the intervention they are more easily presented.

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Prior to the intervention those involved as intervenors should agree upon goals and procedure to be followed as well as who will serve as the coordinator of the intervention. Two alternative courses of action should be presented. It is advisable to consider predictable "escape hatches" to which the person may resort. You can anticipate a variety of

reasons why the person cannot follow either alternative. "My daughter is being married." "My income tax has to be prepared." "I can't possibly find anyone to cover my practice." Someone must be prepared to respond to each of these statements. Even if it is to say, "Dad, I would rather see you get help than be at my wedding." If at all possible a rehearsal of the group may be necessary to have it go smoothly.

The intervenors must be prepared for hostile attacks, the sick person may get up and walk out or he may break down and cry.

The intervention itself may take place in a variety of settings, in a doctor's office, at home, the administrator's office, etc. The most meaningful person should be chosen as the person to lead the meeting. The leader declares the purpose of the meeting openly and directly at the outset. "We are all here because we are concerned about you and want to share our concerns. We would like you to

listen to each of us and then you'll have your turn." The leader will also start the process of data flow by moving to each person and keeping control of the meeting as far as who speaks. Everyone's place in the meeting is described and what they are going to contribute is either implied or directly stated at the outset. After each person has stated their observations and concerns, the two agreed upon alternatives of treatment are offered. The intervenors must be prepared for hostile attacks, the sick person may get up and walk out or he may break down and cry. Rest assured he will try to find other options, but the group must be firm and not accept any but the specified alternatives.

The addict is a sick person whose illness is treatable, but if not treated may be terminal or at least physically destructive. The families of individuals with addictive disease also suffer the devastation if we do not care enough to initiate the intervention process.

- Dr. Morgan, 7400 S.W. 62nd Avenue, Miami 33143.

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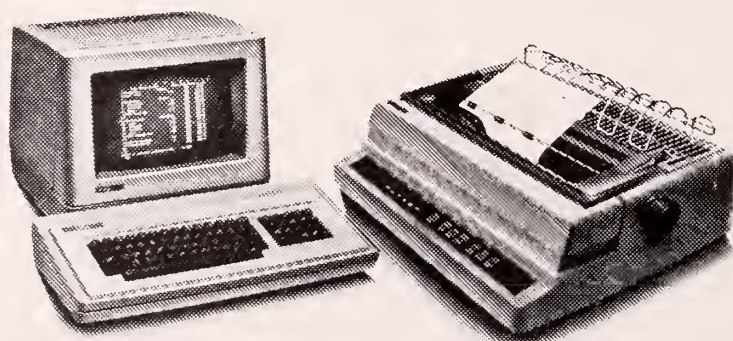


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NOTES & NEWS

William T. Haeck, M.D. honored by emergency physicians

William T. Haeck, M.D., of Ft. Lauderdale is the recipient of the 1982 John G. Wiegenstein Leadership Award for advances made by the American College of Emergency Physicians during his presiding in 1974-75.

Since 1968, Dr. Haeck has held several posts throughout the nation in practice and as a consultant in Emergency Medicine. He helped found the ACEP in 1968 and has served in other leadership positions in addition to the presidency.

Through Dr. Haeck's leadership, the College published the Physician's Evaluation and Educational Review in emergency medicine (PEER I), established the Emergency Medical Services Information Center (EMSIC) at Headquarters, and published *Emergency Department Organization and Management*.

Dr. Haeck is currently chief consultant for the Emergency Medical Services Association in Plantation, Florida and serves as a member of the Board of Directors for the same organization. A graduate of Northwestern Medical School, Evanston, Illinois, he is vice president and a member of the Board of Directors for Haeck, Findeiss, Westmark & Creed, PA.



Dr. Haeck

Endowed chair honors Dr. Politano

Dr. Victor Politano, one of the nation's leading urologists and Chairman of the Department of Urology at the University of Miami School of Medicine, was

honored September 24th with an endowed chair in his name.

Dr. Politano's research and expertise in urology have gained him world renown. In addition to the \$1.5 million endowed chair, recognition was bestowed on him by awards from several countries including Mexico, Colombia and Italy.

In the mid-50's, he developed the Politano Technique for ureteral implantation which has become the standard, acceptable method for correcting reflux. This has saved the kidneys and lives of thousands of children and adults.

His revolutionary work to correct incontinence using Teflon injections has brought relief from the condition to countless people. Furthermore, research is being done under Dr. Politano's guidance to develop an artificial bladder and to correct incontinence with magnetic devices in cases not suited for Teflon injection. Members of the Department of Urology are also conducting extensive research to combat cancer of the prostate, bladder and kidney, and are experimenting with laser beams for tissue repair.

A graduate of Duke University School of Medicine, Dr. Politano joined the University of Miami School of Medicine in 1962. Active in many professional organizations, he recently completed terms as president of the Society for Pediatric Urology and the Southeastern Section, American Urological Association. His writings have been published in innumerable scholarly journals and many major medical textbooks.

Dr. Fred Andrews missing; search called off

The U.S. Coast Guard has called off its search for Frederick C. Andrews, M.D. and his wife, Gloria, of Mount Dora, who disappeared on September 28, 1982 on a return flight from the Bahamas to Ft. Pierce. They left the Bahamas in a Beechcraft Bonanza at 9:05 a.m. bound to arrive at their destination at 10:52 a.m. that day. The Coast Guard searched an area of 8,000 square miles for several days but found no trace of the airplane.

A memorial service was held on Tuesday, October 26th, at the First United Methodist Church in Mount Dora. Individual memorials may be made to the Cancer Fund, Heart Association, Boy Scouts of America or Waterman Hospital in Eustis where Dr. Andrews was a past chief of staff.

Well known in Florida, Dr. Andrews served as Vice President of the Florida Medical Association and the first Chairman of the Council on Specialty Medicine in the 1970's. During 1967-68, he was President of the Florida Academy of Family Physicians. Dr. and Mrs. Andrews are survived by their daughter, Mrs. Sara Andrews Carson, and three sons, Phillip, John and David.

Southern council of medical deans elects Dr. Deal chairman

Dr. William B. Deal, dean of the University of Florida's College of Medicine and UF associate vice president for Clinical affairs, is the newly elected chairman of the Southern Council of Medical Deans.

Dr. Deal's election to the council's top administrative position took place at the group's recent fall meeting in Sarasota.

The Southern Council, which includes representation from 49 of the nation's 127 medical colleges, is the largest regional group within the American Association of Medical Colleges' Council of Deans. The medical school administrators who hold membership in the Southern Council represent colleges extending from as far north as Maryland, south to Puerto Rico, and west to Texas.

The Southern Council, which meets several times each year, serves as a forum for deans to discuss mutual problems affecting the medical colleges, such as financial support for students and for research. Members of the council also assist the AAMC in lobbying at the national level for legislation regarding medical care, education and research.

Dr. Deal also serves on the administrative board of the AAMC's Council of Deans.



Dr. Deal

Gov. Graham announces campaign against child abuse

Editor's note: The information below was included in a letter to the *Journal* from Gov. Bob Graham requesting assistance towards a public awareness effort on child abuse.

According to Governor Bob Graham, "...child abuse is an immense tragedy that is increasing in Florida and the nation at an alarming rate. Last year more than 70,000 children were reported abused in Florida. Even worse, perhaps as much as two-thirds of all abuse goes unreported. One particular form of abuse, sexual, is especially tragic. A sexually abused child can suffer effects that have serious lifelong impact."

The major goal of the campaign is to encourage people to report suspected abuse. Some disturbing facts include:

- In Florida, 71,522 children were reported abused and/or neglected in 1981-82.
- For every case of child abuse reported, experts estimate that at least two more go unreported.
- Since 1974 reports of child abuse and neglect in Florida have increased by 192 percent.
- For children 1-6 months of age, abuse is the second cause of death, behind Sudden Infant Death Syndrome (SIDS).
- For children 1-5 years of age, abuse is second only to accidents as the cause of death. Many childhood "accidents" are actually abuse disguised.
- Almost 65% of children admitted to Florida's state mental hospitals in 1978 had histories of abuse and/or neglect.

In 1982, the Florida Legislature decreed the prevention of child abuse and neglect to be a priority of the state. To that end, the Interprogram Child Abuse Task Force, which includes people from HRS, the Department of Law Enforcement and the Department of Education, was formed, along with eleven Child Abuse Task Forces located in the eleven HRS districts across the state.

Florida has in existence at least one Child Abuse Protection Team in each of the eleven HRS Districts (total of 15 teams). These innovative teams are composed of physicians, social workers, psychologists, and other human service professionals on call 24 hours a day. The teams provide intensive treatment, therapy and education to victims of abuse and their families. The success rate of the team is exceptionally high.

Florida physicians join attack on pneumonia

An all-out attack on pneumonia and influenza is being launched this winter by concerned physicians in major cities throughout Florida.

The physicians are participating in a national public education effort to alert people who are especially susceptible to contracting pneumococcal pneumonia to the dangers of the disease and to ways of protecting themselves through immunization.

Senior citizens are the most vulnerable to the disease, and the doctors are appearing on radio and television and appearing before groups to discuss the disease and answer questions. Those who feel they are vulnerable to contracting pneumonia are being urged to ask their own doctors about immunization. Those who run the highest risk are people over 50 and those who suffer from diabetes, heart disease, kidney disease, alcoholism or other chronic illnesses, and those who already have influenza.

Among the participating physicians are Thomas B. Williams, M.D. and Inge Holman, M.D. of Pensacola; Alfred H. Lawton, M.D. of Advent Christian Village, Dowling Park; Leonard W. Parkhurst, M.D. of Tallahassee; Melvin Newman, M.D. and Malcolm Foster, M.D. of Jacksonville; Solomon D. Klotz, M.D. of Orlando; G. Frederick Hieber, M.D. of St. Petersburg; Allan L. Goldman, M.D. of the University of South Florida, Tampa; Joseph M. Zeterberg, M.D. of Fort Myers; and Thomas Hoffman, M.D. of the University of Miami School of Medicine.

Physicians, clinics, hospitals and health agencies are being invited to support the campaign by displaying posters and distributing literature about pneumococcal pneumonia and the vaccine to patients.

A supply of 8½"X11" posters and informational brochures can be obtained by writing or calling Judy Dawson, State Coordinator, Florida Pneumonia Prevention Campaign, 7507 Mayfair Court, Tampa, Florida 33614, Phone: (813) 886-1553.

Alcohol research center funded at UF

A nationally designated Alcohol Research Center, funded by a three-year federal grant of \$1.7 million is being established at the University of Florida's Health Center to support extensive investigation of alcohol use and abuse in elderly persons.

Dr. David Challoner, UF vice president for health affairs, announced that the new center "will strengthen and expand a variety of alcohol research projects on this campus bringing a team of 27 medical scientists and allied health specialists into collaborative studies." Dr. Challoner said the multidisciplinary group will focus attention on a topic of concern mandated by the U.S. Congress... "the need for better identification of the causes and consequences of alcohol abuse in our aging population."

"Excessive consumption of alcohol has been identified nationally, and in our state, as a problem of major magnitude," said Dr. Kenneth Finger, UF associate vice president for health affairs and director of the Alcohol Research Center. "There not only is a problem resulting from the increased alcohol consumption that typically occurs during retirement years, but serious health problems that often result from the fact that elderly persons are more sensitive or vulnerable to the deleterious effects of alcohol," Finger said.

"The large economic cost associated with this major social problem includes losses related to decreased work productivity, car accidents and medical care," Dr. Finger added. He said research will be undertaken in several major areas, including studies in

the social, biological and medical sciences. Specific studies will be aimed at assessing the effects of alcohol upon the central nervous system, the cardiovascular system, and upon cell membranes in aging animals (primarily mice and rats).

Appointed scientific director of the new center is Dr. Gerhard Freund, professor in UF's Departments of Medicine and Neuroscience, and chief of endocrinology at the Gainesville Veterans Administration Medical center. Freund has made extensive contributions to scientific literature concerning the effects of chronic alcohol consumption on learning, on memory and on the aging process, based on extensive studies in animal models. He serves on the executive committee of the National Council on Alcoholism.

Co-scientific director is Dr. Nathan W. Perry Jr., professor and chairman of the Department of Clinical Psychology in UF's College of Health Related Professions. Dr. Perry has been actively involved in teaching, research and administration at the Health Center for 19 years.

A group of 24 additional scientists from the Colleges of Medicine and Health Related Professions, the Colleges of Liberal Arts and Sciences, Education and Engineering have been appointed to the faculty of the research center. Members of the advisory board for the center include Dr. William B. Deal, dean of the College of Medicine; Dr. Richard R. Gutekunst, dean of the College of Health Related Professions; Dr. Wayne Chen, dean of the College of Engineering; Dr. Leonard Hayflick, director of UF's Center for Gerontological Studies; and Dr. Charles F. Sidman Jr., dean of the College of Liberal Arts and Sciences.

New WC fee schedule effective October 1

The 1982 Florida Workers' Compensation Medical Service Fee Schedule went into effect on October 1 after a three-month delay caused by litigation.

All medical services provided on and after October 1, 1982 will be reimbursed according to the new schedule, according to the State Division of Workers' Compensation. FMA was successful in obtaining an increase in fees to the 66 2/3 percentile.

The increase had been scheduled for implementation last July, but it was delayed because of a lawsuit filed by a group of Palm Beach County orthopedists. The suit was withdrawn during the summer, clearing the way for implementation of the new fees.

Physicians wishing to obtain a copy of the new fee schedule should contact: Office of Medical Services, Division of Workers' Compensation, Suite 205, Lafayette Building, 2551 Executive Center Circle W., Tallahassee, FL 32301, telephone 1-800-342-1741.



Medical curriculum revision?

A major assessment of medical education took place eight decades ago in the Flexner report. During the late 1960's and early 1970's, numerous curricular revisions occurred as a result of social, academic and economic concerns. Many of the changes, such as the three year curriculum, were experimental and have since been discarded. We are now entering a period of both self-examination and intensified public scrutiny.

Every physician who reads contemporary medical publications is bombarded with evidence of the continuing evolution of medical practice. Computerized axial tomography was recently introduced as the ultimate diagnostic tool. Since this ultimate introduction, Nuclear Magnetic Resonance, has been developed and looms on the horizon to perhaps outdistance CT scanning in clinical usefulness.

The information explosion continues, demanding that every physician become and remain a lifelong student in order to practice the highest quality medicine. Computers will aid in this by providing the tools to gather, store and retrieve data. However, computer literacy is a requisite for this endeavor. Most of us (probably the majority) have little or no training in this area and must therefore become educated before utilizing this breakthrough.

Our patients are much more sophisticated and informed than ever before, and demand explanations in all phases of their care. Difficult dilemmas must be faced and judgments made. We must have the where-with-all to deal with these aspects of medical practice.

Future directions • As we evaluate these changes in the practice of medicine in light of current economic forces, a natural consequence is to once again revisit the matter of the medical curriculum. This is one of the significant issues facing us in medical schools as well as those of you in medical practice. The American Medical Association through its Council on Medical Education has been addressing this subject and recently passed its recommendation for "Future Directions for Medical Education." This document which will be available shortly, addresses various aims and goals for the entire spectrum of medical education.

In an effort to gain a viable perspective, and to assess the need to alter curricula in the future, the Association of American Medical Colleges has launched a three year study of the curriculum content of pre-medical and medical education. The project is funded by a grant from the Henry J. Kaiser

Family Foundation and is entitled "An Overview of the General Professional Education of the Physician and College Preparation for Medicine and Questions that should be addressed." Information is being gathered regarding requirements, courses, manner of presentation, etc. This information will be evaluated by a national committee and recommendations will follow.

Those of us involved with medical education feel certain that this is an appropriate study to be conducted at this time. Hopefully, serious consideration will be given to any suggested curriculum modification as well as the impact upon future practitioners. We hope to have the answers to many of the "nagging" questions which abound concerning the education of physicians.

How should this be presented and when?

What is the role of Humanities in Medicine?

How can we engender lifelong learning habits?

If we can answer these questions and others and begin to modify our curricula accordingly, these studies will have served an important role in the evolution of medical education and the physician of the future.

James A. Hallock, M.D.

Assistant Director, Medical Center

Deputy Dean, College of Medicine

University of South Florida



CORRESPONDENCE

On the intensive care burn unit

Editor's note: Hal G. Bingham, M.D., University of Florida wrote "Does an intensive care burn unit really make a difference?" which appeared in the October issue [Vol. 69, Number 10]. John Snow, M.D. has written some comments on the article for general publication.

To the editor: I found Dr. Bingham's paper in the October *Journal* to be informative. The treatment at the University of Florida compares favorably with that of other burn centers where a number of physicians can work as a team in treating burns thereby reducing anesthesia time and make possible the enormous quantity of time necessary for this type of case.

As stated, I think this paper is informative and the treatment at the University of Florida compares favorably with that of other burn centers where a number of physicians can work as a team in treating burns thereby reducing anesthesia time and make possible the enormous quantity of time necessary for this type of case.

I think the treatment of the 70-80% third degree burns at the University of Florida is notable, although all expired at a much later date than the mean throughout the country. I think this probably reflects a difference in outlook of those treating the burn more than anything else. However, since this paper was submitted an article in *Plastic and Reconstructive Surgery*, from Shanghai, showed the Chinese's experience using allografts and scattered homografts to be far superior to that obtained in the U.S.A., i.e., 40-50% survival in 70-80% third degree body burns group. They attribute this to utilization of allografts which are undoubtedly easier to obtain there than here plus the use of small islands of homografts cropped from the scalp which seems to re-epithelialize much faster over the melting allografts than when simply applied in isolation. They report that the scalp has been recropped as many as 19 times to obtain split thickness grafts without inhibiting subsequent hair growth which initiates from just below the deep dermis.

I am sure the burn center at the University of Florida is well aware of this publication and since they have demonstrated their ability to keep 70-80% of third degree body burn patients alive for an average of six weeks, the Chinese's modification should be easily inserted in the burn protocol with anticipation of a significant increase in survival.

Perhaps the authors would do well to visit the Shanghai burn center to personally observe their method of treatment since survival rate in the 70-80% body burns is now zero here.

Congratulations to the persistence and care rendered by the authors in these demanding cases and hopefully the future will be more hopeful in the large percentage body burns.

John W. Snow, M.D.
Jacksonville

Renal transplantation

To the editor: In the October issue of *The Journal*, Richard J. Howard, M.D. et al. reported experiences with 500 renal transplants performed at the University of Florida from 1966 to 1982. The results compare well with results reported from other centers. Two points addressed in this report have especially noteworthy implications for patients with chronic renal failure: (1) the progressively improving results of renal transplantation; and (2) the effectiveness of transplantation as compared with dialysis.

In this series of patients, both patient survival and graft survival progressively increased during the time span of the study. This was true with both living related donor and cadaveric donor renal transplants, and it was true despite the fact that various high-risk categories of potential recipients had been excluded from consideration during the early years, and more and more included during the recent years. Patient survival at two years post-transplant during the recent years had increased to around 90% or better. Graft survival at two years had increased to 84% of grafts from living related donors to 64% of grafts from cadaveric donors. The progressive improvement could not be attributed to any particular breakthrough. Rather it was attributed to numerous advances affecting the management of the patients before, during, and after the transplant hospitalization. All of this is consistent with experiences at other centers.

In a brief discussion of the comparative effectiveness of renal transplantation and dialysis, the authors acknowledge the progressively improving results with both modalities, and they properly note that no scientifically controlled comparative study has yet been published. As a practical matter, however, it is necessary to compare the two modalities whenever planning the management of individual patients; and the two major considerations are age of patient and category of donor. After the age of 60 very few patients receive renal transplants but, as Howard et al. point out, apparent age and state of health are more significant than age per se. In the range of 45 to 60 years, age is a consideration, but age alone is usually not decisive. With respect to the three principal categories of donor: (1) If an HLA-identical sibling donor is available, renal transplantation is by far the treatment of choice; and one-fourth of potential sibling donors are in this category. In this category the expected patient survival at two years is 90 to 100% (depending upon the risk factors); and two-year graft survival is 90 to 95%.¹⁻³ (2) With other living related donors the results are somewhat less favorable; however, if such a donor is available, transplantation is decidedly preferable to dialysis, particularly if the donor is a parent or other HLA-haploidentical relative. (3) If only cadaveric donors can be considered there are still advantages to transplantation, and the authors list these in their discussion. Patients under 45 years of age mostly prefer transplantation and as a rule, the younger the patient, the stronger this preference.

Finally, the advances that are continuing to evolve with transplantation and with dialysis need to be followed closely. One example is the potent new immunosuppressant, cyclosporin A, the impact of which has not yet been fully defined. It appears, however, that this new drug is a major

breakthrough. The favorable results now being achieved with renal transplantation are thus likely to be advanced even further in the foreseeable future.

*Delford L. Stickel, M.D.
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Duke University Medical Center
Durham, North Carolina*

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WORTH REPEATING

Should the FTC regulate American medicine?

Congress is expected to act soon on legislation to reauthorize the Federal Trade Commission. At that time, it must decide whether the FTC will have authority to regulate licensed professions, such as doctors, lawyers and dentists. The policy established by Congress on this issue could have drastic consequences on medical care delivery in the United States for the next generation.

Congress should rein in the FTC and direct it to pursue the functions for which it was created — to prevent anticompetitive and deceptive practices by American business. The FTC's overzealous administrators are chipping away at the foundations of American medicine. The standards of quality established by the American Medical Association and other medical societies — criteria that made health care in America the finest in the world — are being undermined by a federal agency that possesses no medical qualifications.

The FTC does possess enormous resources. With its \$68 million annual budget and extensive staff and facilities, it overwhelms the targets of its investigations with complex subpoenas, lengthy hearings at which the "judge" is employed by the FTC, and seemingly unlimited legal resources for administrative and court actions.

The AMA and other medical associations have already spent millions responding to FTC requests for information and defending against FTC complaints. In many cases, state and local medical asso-

ciations have chosen to settle with the FTC rather than continue a fight that would cost them far more than they could afford. The real losers are the American people, because all that money should have been spent on the many public interest functions performed by medical societies. If Congress doesn't act, even more will be at stake for the consumer in years to come.

The genesis of the problem goes back to 1975, when the FTC plunged into regulation of professions by filing a complaint against the American Medical Association. It charged, among other things, that principles of medical ethics prohibiting physician advertising were anticompetitive and violated the Federal Trade Commission Act. Had the commission bothered to speak with AMA officials before filing the complaint, they would have known that the association was in the process of modifying its existing standards in response to a 1975 Supreme Court ruling on physician advertising.

In the ensuing seven years, the FTC has intruded more and more pervasively into the practice of medicine in this country. The commission began to subpoena records from the AMA and many of its federated state, local and medical specialty societies with regularity. When a medical society is targeted for an FTC fishing expedition, the costs are enormous in money and manpower.

The California Medical Association spent \$1 million defending itself against charges by the FTC that its act of publishing a "relative value study," which compares charges for specific services in various locales, amounted to price fixing. The CMA finally settled the case after determining that it could not afford the more than \$4 or \$5 million it would take to fight the case all the way. The relative value study, which helps consumers compare prices, has been published in other states as well. Ironically, authorities are considering these studies as the basis for reimbursement for medicaid and medicare programs.

The list of costly, time-consuming actions initiated by the FTC in recent years seems endless. The real tragedy is that they are preventing the medical associations from performing the functions at which they have excelled since the AMA was founded in 1847. Here are some of the effects of continued FTC regulation of licensed professions:

1. Medical standards that protect patients from unethical practices will no longer be set by medical societies — the groups responsible for the consistently high quality of performance in American medicine. The FTC has prohibited medical societies from "interfering with, or impeding the growth, development or operations of any entity that offers physicians' services to the public."
2. Guidance on what constitutes reasonable fees

for specific medical treatment would no longer be available from local medical societies. The FTC has, in effect, ordered these groups to refrain from commenting on such inquiries. Instead, the medical associations would be allowed only to conduct peer review of physicians' fee "practices" over a long time.

3. Warnings about physician's groups, clinics, or medical services organizing who have poor performance records could not be given to consumers by any local society. These groups are now prohibited by the FTC from any action that would "limit the patient's choice of a physician."
4. Voluntary coalitions to contain rising medical costs would be off-limits to representatives of medical societies. Even though the AMA and its federated associations have achieved success with voluntary cost containment programs in many areas, the FTC would prohibit such action as price-fixing.

The constant drain on medical societies' resources because of FTC administrative procedures can hinder these groups from performing their most important functions, such as peer review processes; continuing education programs for doctors in the field who have an average career span of 40 years and need to keep up with new discoveries; programs to deal with physicians who suffer from problems like alcoholism or drug abuse; and systems to monitor and assess the fiscal and clinical implications of emerging diagnostic and therapeutic technology.

The medical profession recognizes the need for government scrutiny and enforcement of antitrust laws. This task was performed well through the years by the U.S. Justice Department, state attorneys general, state licensing boards, and the courts. FTC interference was unnecessary and quite removed from the functions for which it was created in 1914.

FTC Chairman James C. Miller III says that regulation of professions by the commission is necessary to promote competition. But there is ample competition now among 400,000 doctors and 7,000 hospitals. The FTC shouldn't try to fix what isn't broken. If Miller is succeeded by a more activist FTC chairman, the yoke on the medical profession could become even more damaging.

For the sake of consumers and the physicians who serve them, the House of Representatives must pass HR 3722, the Luken-Lee bill, which would place a moratorium on FTC action regarding state-regulated professions until Congress expressly authorizes such action. This will be offered as an amendment to HR 6995. The Senate should adopt S 2499, which prohibits the FTC from preempting state laws relating to members of the professions and clarifies that the FTC lacks authority to issue rules affecting any state-

regulated professions and state or national professional associations.

"The greatest dangers to liberty," Justice Louis D. Brandeis once wrote, "lurk in insidious encroachment by men of zeal, well-meaning but without understanding."

It's up to Congress to control the FTC and its zealots, who are threatening the future of medical practice in this country.

*William Rial, M.D.
President
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Reprinted from *National Journal*, September 11, 1982.



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WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient should be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effect caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

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DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours, not to exceed 10 teaspoonfuls in any 24-hour period.

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Moreover, the efficacy and safety of Dalmane for the treatment of insomnia have been demonstrated in thousands of patients with a variety of primary medical conditions, including cardiovascular, neuropsychiatric, endocrine-metabolic, gastrointestinal, genitourinary, respiratory and musculoskeletal disorders.¹ Dalmane (flurazepam HCl/Roche) is contraindicated in pregnancy and in patients hypersensitive to the drug.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

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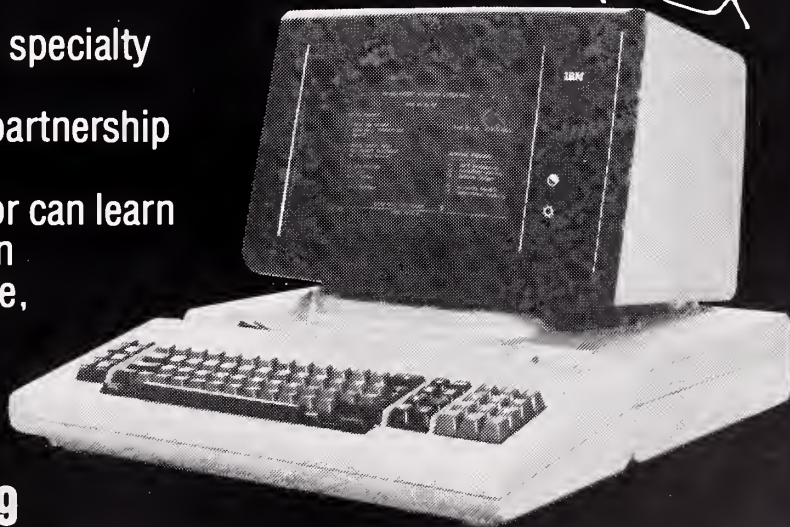
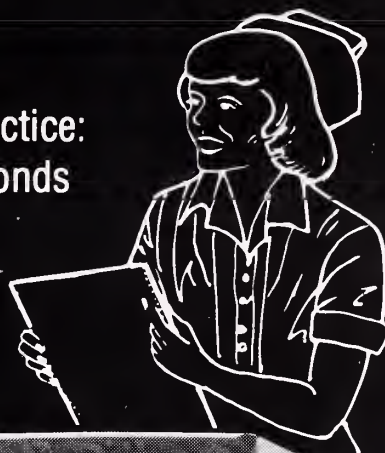
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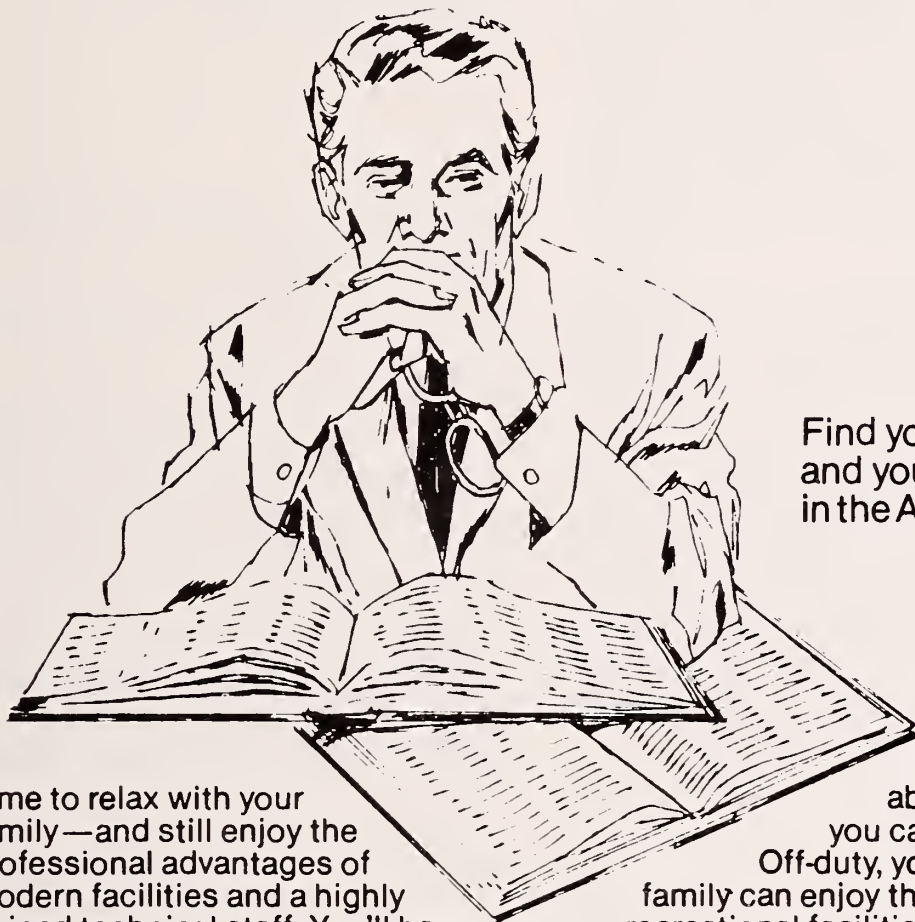
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Book Review Editor — **F. Norman Vickers, M.D.**

Current obstetric & gynecologic diagnosis and treatment

Edited by Ralph C. Benson, M.D., 1038 pages. Price \$25.00. Lange Medical Publications, Los Altos, CA, 1982.

This is the fourth edition of Dr. Benson's well known OB/GYN publication. The first edition was published in 1976 and was primarily intended to appeal to medical students rotating through clinical obstetrics and gynecology and resident physicians in the specialty field. However, the format and content of the book quickly attracted the attention of many physicians already engaged in the practice of obstetrics and gynecology.

The book is comprised of forty-three chapters, each written by different physicians, except for three chapters written by Dr. Benson himself. Many of the authors are recognized as leading investigators in their respective fields. This particular aspect enhances the appeal and credibility of the book.

The subject matter covered includes practically every facet of obstetrics and gynecology that a clinician would encounter. The material presented ranges from a discussion of embryology as it relates to OB/GYN to a section updating maternal and perinatal statistics. There are chapters on such contemporary topics as pediatric and adolescent gynecology, applied genetics, the emotional aspects of pregnancy and the medical-legal considerations of our specialty.

While the book does not cover every subject in great detail, it is nonetheless an excellent reference and guide for the student and practitioner; it is in essence a modern textbook.

During my years in academic OB/GYN I highly recommended the book to medical students and residents. I often refer to the book myself as a source of current information and thinking concerning various OB/GYN topics.

The book is updated with a new and expanded edition every two years, and there are editions printed in Spanish and Portuguese.

For the physicians and physicians-to-be who participate in the health care of women this particular book will be an excellent addition to their library as a *current* reference to clinical obstetric and gynecologic care.

*Pierre J. Bouis Jr., M.D.
Merritt Island*

- Dr. Bouis is in the private practice of obstetrics and gynecology in Merritt Island. He was formerly Associate Professor of Obstetrics and Gynecology at the University of South Florida College of Medicine in Tampa.

The American Medical Association book of backcare

By Marion Steinmann, 177 Pages. Price \$12.95. Random House, New York, 1982.

Developed by the American Medical Association under the medical advice of William F. Donaldson Jr., M.D., and Norman W. Hoover, M.D., this small, concise, easy-to-read book with 54 artist's illustrations, addresses the problem of backache, a condition which plagues nearly 100 percent of human beings during their lifetime.

After describing anatomy of the back in the first 42 pages, the book goes on to describe what happens in the back from conception to old age. It then briefly addresses about 15 of the more common diagnoses of the back. Chapter four describes those common modalities used by physicians in the treatment of back problems. Another chapter tells how to prevent back strains and injuries. The final chapter discusses the role of our upright posture in the cause of back pain, a subject orthopaedic surgeons address to their patients every day.

The book is relatively free of errors, although it does perpetuate the term whiplash, better called acceleration-deceleration injury. The book could serve as an adjunct to patient care in those patients capable and willing to read a specific chapter at the doctor's request. I would strongly recommend this book to any physician who, in daily practice, sees backaches.

*James F. Richards Jr., M.D.
Orlando*

- Dr. Richards is in the private practice of orthopaedic surgery in Orlando.

Fall conference focuses on learning disabilities

A forum on Specific Learning Disabilities was held at the Fall Conference of the Florida Medical Association Auxiliary. This major educational and sociological problem was discussed from the point of view of four disciplines: pediatrics, neurology, psychiatry and psychology.

Dr. Frank Carrera, Chief of the Division of Child and Adolescent Psychiatry at the University of Florida presented a case study of a Learning Disabled child. His treatment, behavior modification, included the family and school which he felt were imperative for successful results.

About 25% of children with Learning Disabilities develop a need for psychiatric help, according to Dr. Carrera. The emotional overlay resulting from school failures and inability to cope with family and peers has a serious effect on the child. He stated that the 1980 edition of psychiatric textbooks are the first to discuss treatment of this problem.

Dr. Louis Poetter, a psychologist, is founder of Anneewakee, Inc., in Douglasville, Georgia. Founded in 1962, the facilities have been expanded to three campuses. Dr. Poetter said that Learning Disabled children often have difficulty with the

social learning process beginning in infancy. He demonstrated the absolute necessity of reinforcement learning in this area. Subtle body messages are not correctly interpreted by Learning Disabled children. Despite high I.Q.'s this group is unable to function in the complex world because of their inability to identify with others.

Dr. James Nealis, a pediatric neurologist from Jacksonville, spoke of the complexity of physical symptoms found in the Learning Disabled. He stressed the fact that although strengths and weaknesses are found in all people, the Learning Disabled have more functional differences than the average person.

Dr. Richard Skinner, a Jacksonville pediatrician, has established a reputation for early identification of Learning Disabilities in children. He presented signs he looks for on examination and described Learning Disabled children as being neurologically different. His long experiences have led him to believe that constant shifting of teaching methods when immediate success is not seen has caused further academic difficulties.

Our panel concurred that a multi-discipline approach is imperative for successful treatment.

*Mrs. James Jude (Sallye)
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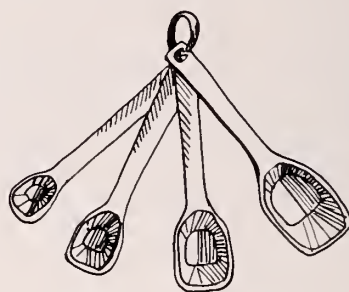
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4 egg yolks, well beaten	1/2 tsp. cream of tartar
1 can sweetened condensed milk	1/4 cup sugar
1/2 cup lime juice (4-6 limes)	1 9" graham cracker pie shell, baked
6 egg whites*	

In a small mixing bowl beat egg yolks until lemon-colored. Blend in condensed milk. Add lime juice, mix well. In a large mixing bowl beat egg whites and cream of tartar until foamy. Continue beating, adding sugar 1 tablespoon at a time until egg whites peak. Fold 6 tablespoons of meringue into the filling mixture. Pour into pie shell. Top with meringue and bake in a slow 330°F oven for about 30 minutes or until golden brown. Best served chilled. May be frozen and kept for a couple of days before serving.

*You can make the meringue with only 4 egg whites from the eggs you've used.

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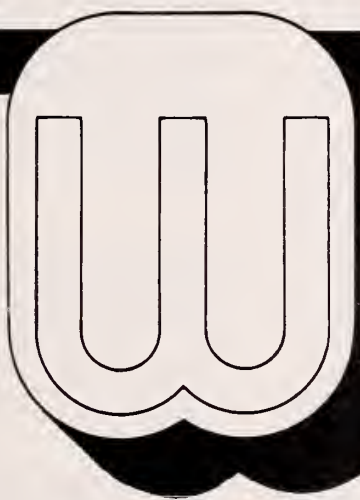
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DECEMBER

Florida Obstetric and Gynecologic Society Annual Meeting, Dec. 2-5, South Seas Plantation, Captiva Island. For information: Allan G.W. MacLeod, M.D., Dept. of OB/GYN, University of Miami School of Medicine, P.O. Box 016960, Miami 33101.

Clinical Allergy & Immunology for the Practicing Physician, Dec. 2-4, Dutch Inn Resort Hotel, Lake Buena Vista. For information: Richard Lockett, M.D., Univ. of South Florida, College of Medicine, Division of Allergy, (813) 971-4500, Ext. 596.

Neuro-Ophthalmology, Dec. 2-4, Miami. For information: Univ. of Miami School of Medicine, Dept. of Ophthalmology (D880), P.O. Box 016960, Miami 33101, (305) 547-6540.

ECG Interpretation and Arrhythmia Management, Dec. 3-5, Bahia Mar Hotel, Ft. Lauderdale. For info.: International Medical Education Corp., Division of Postgraduate Education, 64 Inverness Drive E., Englewood, Colorado 80112.

Advances in Technology for the Management of Musculoskeletal Disability, Dec. 6-8, Miami. For information: Univ. of Miami School of Medicine, Dept. of Orthopedics (D27), P.O. Box 016960, Miami 33101.

Human Sexuality, Dec. 8-11, Disney World, Orlando. For info.: Pat Taylor, c/o Pedro Bachrach, M.D., 701 E. Semoran Blvd., #108, Altamonte Springs 32701. (305) 323-7772.

Ultrasound As Used In Modern Obstetrics and Gynecology, Dec. 8-12, Miami Beach. For information: Univ. of Miami

School of Medicine, Dept. OB/GYN, P.O. Box 016960, Miami 33101.

Percutaneous Transluminal Coronary Angioplasty Update, Dec. 10, Miami Heart Institute, Miami Beach. For info.: Paul S. Swaye, M.D., 305/672-1111, Ext. 4193.

Modern Concepts in Clinical Aspects of Epilepsy, Dec. 11, Sheraton Regency Resort Hotel, Vero Beach. For information: Neurological Associates, 2800 S. Ocean Drive, Vero Beach 32960.

Interamerican Medical Symposium — 3rd Annual Course, Dec. 12-17, Miami Beach. For information: Dept. of Medicine (R760), P.O. Box 016960, Miami 33101.

JANUARY 1983

Medical Sociology, Jan. 6, Holy Cross Hospital, Ft. Lauderdale. For information: Jon Fichtelman, M.D., P. O. Box 23460, Fort Lauderdale 33307, (305) 771-8000 Ext. 5728.

28th Annual Cardiovascular Seminar, Jan. 7-8, Dolphin Beach Resort, St. Petersburg Beach. For information: Mr. E. Jerry Eatman, P.O. Box 7188, St. Petersburg 33734.

6th Annual Review in Oral Pathology, Jan. 10-14, University of Miami, Miami. For information: University of Miami CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

Grand Prix Road Racing — Medical Aspects, Jan. 12, Peace River Country Club, Bartow. For information: Mrs. Elsie Trask, Exec. Dir., Polk County Medical Society, (813) 682-0543.

Coexistent Pulmonary and Cardiac Disease, Jan. 12, Mount Sinai Medical Center, Miami. For information: Marvin L. Meitus, M.D. and Adam Wanner, M.D., 4300 Alton Road, Miami Beach 33140, (305) 674-2311.

Youth and Hypertension: The Challenge for Today, Jan. 13, Brickell Point Holiday Inn, Miami. For information: G. L. Sanders, M.D., (305) 757-0113/547-6593.

2nd International Advanced Arthroscopic Update, Jan. 12-15, Sand Piper Bay, Port St. Lucie. For information: Ronald Grober, M.D., 2000 Nebraska Avenue, Ft. Pierce 33450, (305) 464-3657.

The Second Biennial Palm Beach Aesthetic Surgery Symposium, Jan. 13-16, The Breakers, West Palm Beach. For information: Douglas D. Dedo, M.D., 1515 N. Flagler Drive, West Palm Beach 33401, (305) 659-2266.

8th Annual Review & Recent Practical Advances in Pathology, Jan. 17-21, University of Miami, Miami Beach. For information: Univ. of Miami School of Medicine, Dept. of Pathology, P.O. Box 016960, Miami 33101, (305) 325-6437.

Calcium Blockers for the Treatment of Angina Pectoris, Jan. 18, Holy Cross Hospital, Ft. Lauderdale. For information: Jon R. Fichtelman, M.D., P.O. Box 23460, Ft. Lauderdale 33307, (305) 771-8000, Ext. 5828.

15th Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 19, Sheraton Bal Harbor Hotel, Miami Beach. For information: Victor Politano, M.D., 6614 Miami Lakes Drive East, Miami Lakes 33014, (305) 687-1367.

Acute Spinal Cord Injury — Comprehensive Management, Jan. 19-23, University of Miami, Miami. For information: CME, University of Miami School of Medicine, P.O. Box 016960, Miami 33101, (305) 547-6716.

Continuing Education in Pediatrics - 1983, Jan. 23-27, Diplomat Hotel, Hollywood. For information: Donald H. Altman, M.D., 6125 Southwest 31st Street, Miami 33156, (305) 667-7060.

Twenty-First Annual Seminar "What's New in Diagnostic

Imaging and Interventional Techniques, Jan. 23-28, Sheraton Bal Harbour, Bal Harbour. For information: Lucy R. Kelley, Radiology Seminars, Inc., P. O. Box 343762, Coral Gables 33134.

Advances in Orthopedics — 1983, Jan. 26-28, Holiday Inn Surfside, Clearwater Beach. For information: Deborah Smelt, USF, Box 36, Tampa 33612.

Round Table Day, Jan. 28, Diplomat Resorts, Hollywood. For information: D.H. Altman, M.D., 6125 Southwest 31st St., Miami 33156, (305) 667-7060.

Symposium on Intensive Care, Jan. 29 - Feb. 5, Vail, Colorado. For information: University of Miami School of Medicine, P.O. Box 016960, Miami 33101, (305) 325-6726.

Pediatric Nephrology Seminar X, Jan. 30-Feb. 3, University of Miami, Miami. For information: University of Miami, Department of Pediatrics, P.O. Box 016960, Miami 33101, (305) 325-6726.

The 10th Annual Symposium in Pediatric Nephrology; Current Concepts in Diagnosis and Management, Jan. 30 - Feb. 3, University of Miami, Miami. For information: Univ. of Miami School of Medicine, Department of Pediatrics, P.O. Box 016960, Miami 33101, (305) 325-6726.

FEBRUARY

Clinical Approach to Exercise Testing, Feb. 3-5, Hyatt Orlando, Orlando. For info.: Stephen P. Glasser, M.D., Univ. of South Florida College of Medicine, Box 19, 12901 N. 30th Street, Tampa 33612, (813) 974-2880.

10th Annual George F. Paff Seminar, Feb. 4-6, Ft. Lauderdale. For information: Univ. of Miami, Division of Continuing Medical Education, P.O. Box 016960, Miami 33101, (305) 547-6716.

Third Annual Treasure Coast Medical-Surgical Review, Feb. 5-6, Dodgertown Conference

Center, Vero Beach. For information: John L. Rodgers, M.D., P.O. Box 573, Vero Beach 32960, (305) 567-9711.

The Postgraduate Seminar in the Fundamentals of Otolaryngic Allergy and Clinical Applications, Feb. 5-10, Don CeSar Beach Resort, St. Petersburg Beach. For information: Hueston C. King, M.D., 4675 Ponce DeLeon Blvd., Miami 33146.

9th Annual Conference on Anesthesiology, Feb. 5-12, Vail, Colorado. For information: Univ. of Miami School of Medicine, Dept. of Anesthesiology (R370), P.O. Box 016960, Miami 33101, (305) 547-6411.

Internal Medicine 1983 — 18th Annual Postgraduate, Feb. 6-11, Miami Beach. For info.: Univ. of Miami School of Medicine, P.O. Box 016960, Miami 33101, (305) 547-6063.

Topics in Geriatric Medicine, Feb. 10-12, Diplomat Resort and Country Club, Hollywood. For information: Kevin Newman, M.D., (305) 841-5144.

Prostaglandins in Medicine, Feb. 11-12, The Dutch Inn, Lake Buena Vista. For information: Ms. Grace Wagner, University of Florida, Box J-233, JHMHC, Gainesville 32610, (904) 392-3143 or 392-3183.

10th Annual Homecoming Symposium, Feb. 11-12, Sonesta Beach Hotel, Key Biscayne. For information: University of Miami School of Medicine, Department of Psychiatry (D29), Post Office Box 016960, Miami 33101, (305) 325-6335.

Florida Midwinter Seminar in Ophthalmology, Feb. 14-16, West Palm Beach. For info.: University of Miami School of Medicine, Department of Ophthalmology (D880), P.O. Box 016960, Miami 33101, (305) 547-6540.

Florida Midwinter Seminar in Otolaryngology, Feb. 17-19, West Palm Beach. For information: University of Miami School

of Medicine, Department of Ophthalmology (D880), P. O. Box 016960, Miami 33101, (305) 547-6540.

Clinical Management of the Elderly Patient for the Practicing Physician & Other Health Professionals, Feb. 18-19, Americana Dutch Inn, Orlando. For information: L. Gregory Pawlson, M.D., M.P.H., Rm. 322, 1229 25th St., N.W., Washington, D.C. 20037.

The 7th Annual Symposium in Clinical Cardiology, "Cardiovascular Pharmacology", Feb. 18-19, Sheraton Sand Key Hotel, Clearwater. For info.: Donald R. Eubanks, M.D., Morton F. Plant Hospital, 323 Jeffords Street, Clearwater 33517, (813) 441-5166.

Arrhythmias & Cardiac Ischemia: Diagnosis & Management, Feb. 19-24, Bahia Mar Hotel, Ft. Lauderdale. For information: International Medical Education Corp., 64 Inverness Dr. E., Englewood, Colorado 80112, (800) 525-8651.

The 4th International Workshop on Neurological Surgery of the Ear and Skull Base, Feb. 19-24, Hyatt House, Sarasota. For Information: Marcia Gordon, Sarasota County Medical Society, 1845 Hillview Street, Sarasota 33579, (813) 366-2700.

International Radiology Conference, Feb. 20-Mar. 6, Tokyo-Hong Kong-Honolulu. For information: Lucy R. Kelley, Radiology Seminars, Inc., P.O. Box 343762, Coral Gables 33134.

Conference on the Beach - 4th Annual Family Practice Update, Feb. 21-26, Daytona Hilton, Daytona Beach. For information: Richard W. Dodd, M.D., (904) 258-1584.

Hepatobiliary Disease in Clinical Practice V, Feb. 24-26, Sheraton Bal Harbour, Bal Harbour. For information: University of Miami School of Medicine, Department of Continuing Medical Education (D23-3), P.O. Box 016960, Miami 33101, (305) 547-6716.

10th Pediatric Dermatology Seminar, Feb. 24-27, Carillon Beach Hotel, Miami Beach. For information: Guinter Kahn, M.D., Parkway Hospital Medical Plaza, Suite 401, 16800 N.W. 2nd Ave., North Miami Beach 33169, (305) 652-8600.

Peripheral Vascular Disease for the Non-Surgeon, Feb. 25, Royal Palm Yacht Club, Fort Myers. For information: Warren E. Hagen, M.D., 3596 Broadway, Fort Myers 33901, (813) 936-8555.

Spine Surgery, Back to Basics, Feb. 28-March 3, Kissimmee. For information: Univ. of Miami School of Medicine, Department of Orthopedics (D27), P.O. Box 016960, Miami 33101, (305) 547-6996.

Basic Neurology for Psychiatrists and Generalists, Feb. 28-March 4, Miami Beach. For information: University of Miami School of Medicine, Department of CME, Post Office Box 016960, Miami 33101, (305) 547-6716.

MARCH

15th Teaching Conference in Clinical Cardiology, Mar. 2-5, The Sheraton Bal Harbor Hotel, Bal Harbor. For information: Michael Gordon, M.D., University of Miami School of Medicine, Medical Training & Stimulation Lab., P.O. Box 016960, Miami 33101, (305) 547-6491.

Breast Disease Update, Mar. 2-6, Dutch Inn, Lake Buena Vista. For information: Lourdes S. Fuentes, Mount Sinai Medical Center, 4300 Alton Road, Miami 33140, (305) 674-2424.

Current Topics in Internal Medicine, March 3-5, PGA Sheraton Resort, Palm Beach Gardens. For info.: Michael C. Schweitz, M.D., (305) 659-4242.

Internal Medicine Update '83, Mar. 7-12, Americana Dutch Resort Hotel, Lake Buena Vista. For information: Barry E. Sieger, M.D., 1414 South Kuhl Avenue, Orlando 32806, (305) 841-5144.

Hematology-Oncology Update, Mar. 8-11, Holiday Inn Surfside, Clearwater. For information: Robert Miller, M.D., 701 6th St. S., St. Petersburg 33701, (813) 823-1234, Ext. 2022.

Fourth Annual Pediatric Neurology Postgraduate Course, Mar. 9-12, Eden Roc Hotel, Miami Beach. For information: Michael Duchowny, M.D., 6125 S.W. 31st St., Miami 33155, (305) 666-6511.

Problems in Rheumatology, Mar. 10-13, Don CeSar Beach Resort Hotel, St. Petersburg. For information: Bernard Germain, M.D., Univ. of South Florida, Box 19, 12901 North 30th Street, Tampa 33612, (813) 974-2681.

Fifth Annual Winter Seminar of the Miami Ophthalmological Society, Mar. 12-19, Sun Valley Lodge, Sun Valley, Idaho. For information: David J. Singer, M.D., F.A.C.S., 1160 Kane Concourse, Miami Bch. 33154, (305) 861-4946.

14th Annual Topics in Internal Medicine, Mar. 17-18, Gainesville Hilton, Gainesville. For information: Ms. Grace Wagner, University of Florida CME, JHMHC, Box J-233, Gainesville 32610, (904) 392-3143 or 392-3183.

5th Annual Family Practice Review, Mar. 21-25, Holiday Inn Surfside, Clearwater Beach. For information: C. E. Aucremann, M.D., 701 Sixth Street South, St. Petersburg 33701, (813) 823-1234.

Interesting Topics in Orthopedics: 1983, Mar. 24-26, PGA Sheraton Resort, Palm Beach Gardens. For info.: Michael S. Zeide, M.D., 7820 Edgewater Dr., West Palm Beach 33406, (305) 967-8866 or 832-5167.

Orthopaedics for Family and Emergency Physicians, Mar. 24-26, Royal Plaza Hotel, Lake Buena Vista. For info.: Allan March, M.D., (904) 392-1161.

Recent Advances in Nuclear Medicine Instrumentation, Mar. 24-26, Miami. For information: University of Miami School of Medicine, P.O. Box 016960, Miami 33101, (305) 547-6716.

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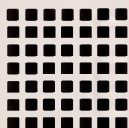
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WANTED FAMILY PHYSICIAN, ABFP required. Central Florida area. Negotiable terms. To join established physician ABFP. Reply to C-1085, P.O. Box 2411, Jacksonville, Florida 32203.

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FLORIDA/Family Practice Residency Program in sophisticated community hospital, University of Florida College of Medicine, Dept. of Community Health & Family Medicine is looking for faculty with practice experience at Assistant/Associate Professor level. M.D., board certified in Family Medicine or Internal Medicine required. Duties include teaching, patient care & related scholarly activities. Recruiting deadline: 12/10/82; anticipated start date: 04/01/83. Send resume to R. Whit Curry Jr., M.D., Family Practice Medical Group, Inc., 625 SW 4th Avenue, Gainesville, FL 32601. An Equal Employment Opportunity & Affirmative Action Employer.

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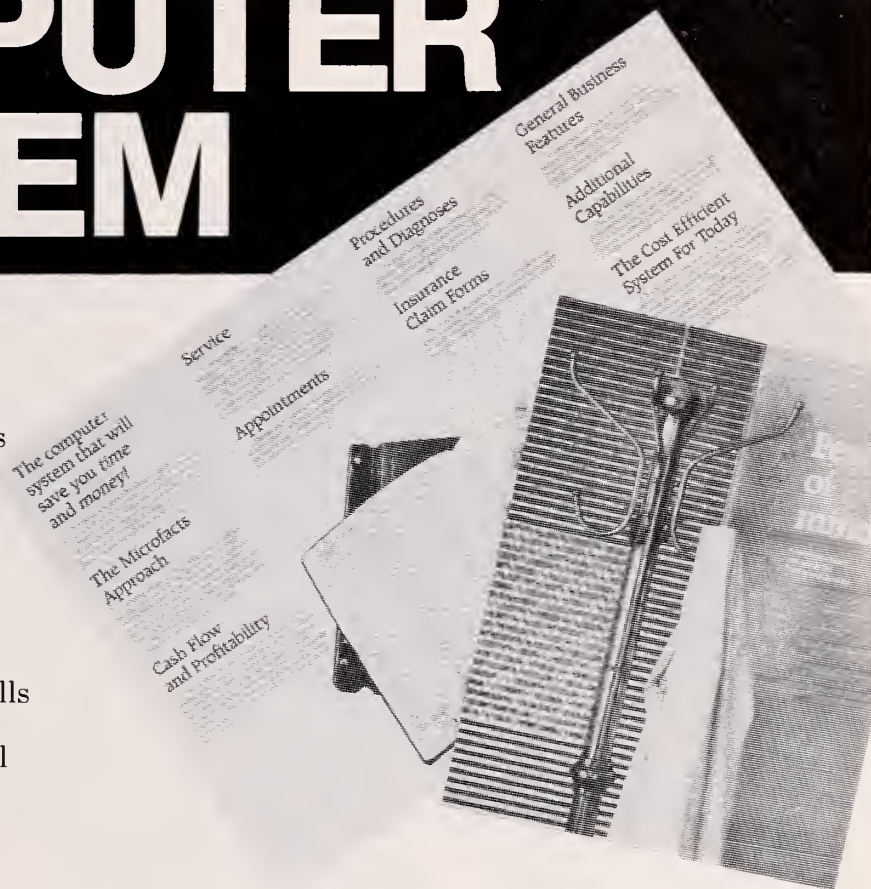
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COVER

The English hawthorn and orange blossom presentation pieces on the cover are by the master jeweler, Peter Carl Faberge (1846-1920). The exhibition, "Treasures by Peter Carl Faberge" is on display at the Cummer Gallery of Art, Jacksonville, Florida, through January 16, 1983. The exhibition is on loan from the Matilda Geddings Gray Foundation in New Orleans.

These exquisitely crafted works by Faberge are made of both precious and semi-precious stones. The ten hawberries are of red and white agate. The piece has a gold stem, leaves of Siberian nephrite (a form of jade), and a vase of white agate with gold soil. The orange blossoms are carved of white and orange tinted jade. The stem is of gold with nephrite leaves. The open blossom has a center of olivine. The blossom spray is held in a simple container of rock crystal.

Photography is by Mr. Larry Amato.

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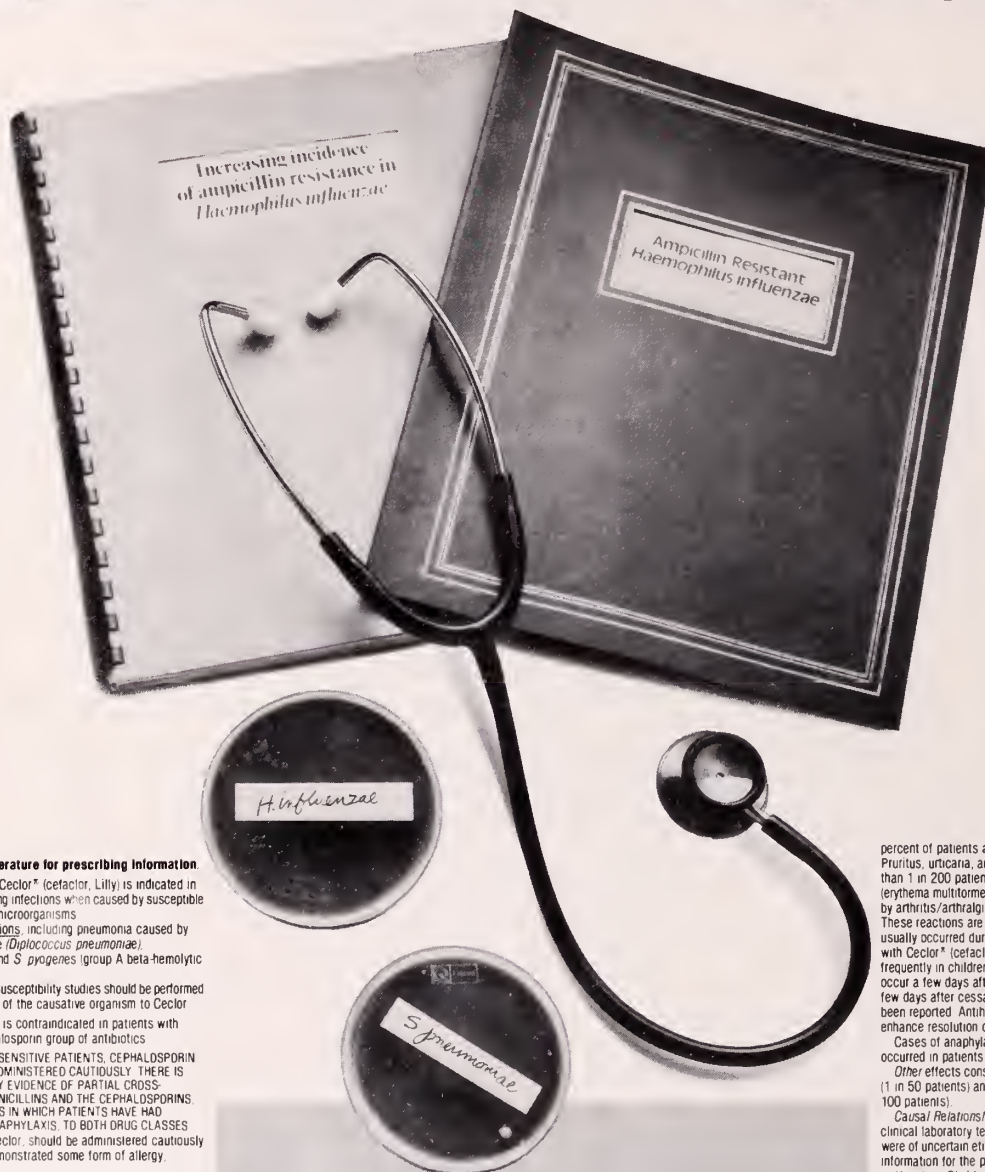
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An added complication... in the treatment of bacterial bronchitis*



Brief Summary

Consult the package literature for prescribing information.

Indications and Usage: Cefclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy:—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy:—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefclor.

Hypersensitivity reactions have been reported in about 1-5

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁵

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefaclor

Pulvules®, 250 and 500 mg

percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/antralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefclor* (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

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7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

200065



Combating the FTC challenge

It is imperative that we who are concerned physicians act now to give the public and our U.S. Congressmen and Senators accurate information about the false claims and assertions that have been made by the Federal Trade Commission (FTC) in its attempts to control our profession. During the Lame Duck Session which began on November 29, Congress will decide whether the FTC can continue its inappropriate, heavy-handed role as a self-appointed arbiter of the medical profession and other state-regulated professions.



Some misguided consumer groups, much of the media and the FTC, itself, have been attempting to mislead the public about the need for the FTC to police the medical profession—unfortunately, they may succeed in convincing members of Congress unless we act now.

We know the FTC has not solved **any** problems involving the medical profession that could not have been handled more appropriately, more efficiently and more cheaply by another agency. We know, in fact, that some of the so-called problems the FTC **claims** it has solved were cases in which charges were unfounded to begin with or cases that had already been resolved at the local level before the FTC intervened.

We know that FTC charges against the medical profession and the fishing expedition the FTC has undertaken have cost taxpayers millions of wasted dollars. The costs of defending against these charges have also led to diverting medical society funds from worthwhile activities—more wasted dollars.

We know the American people do not want Washington interfering in their personal medical care. They want local problems settled locally—as they have been in the past. They want their local and state medical societies to continue to be responsible for acting in their behalf when they need advice about appropriateness of treatment or fees or about false and misleading advertising—claims that can be accurately evaluated only by competent physicians.

We know that the U.S. Department of Justice, state attorneys general, licensing boards and civil courts are appropriately dealing with complaints against physicians, and this further proves that there is no need for the FTC to intercede.

Yes, we know these things. But that is not enough. Now we must respond to inaccurate media reports. We must write, wire and phone members of Congress to clarify the issue and to help them make the right decision on bills pending that will determine the future jurisdiction of the FTC.

Here's what you can do to help on this critical issue. In the Senate, request Senators Hawkins and Chiles to:

- ... Support retention of Section 3, the Stevens Amendment, of S. 2499, which provides that the FTC does not have jurisdiction over the professions.
- ... Support language in the next continuing appropriations resolution (if Congress extends FTC authority through a resolution) that would prohibit use of funds by the FTC to regulate the professions.

In the House of Representatives, ask your Congressman to:

- ... Oppose the Broyhill substitute.
- ... Support the Luken-Lee Amendment which would prohibit the FTC from exercising jurisdiction over the professions unless given specific authorization from Congress to do so.

Each of us in the medical profession must become knowledgeable about the myths and the facts in this issue—and all of us must take the time to speak out. Both our Association and the AMA can supply you with further information on this issue if needed. Don't put off acting! Please set aside some time today and do your part which will be greatly appreciated by all of us everywhere in addition to being of primary benefit to our patients.

Robert E. Winslow, M.D.

P.S. Thanks to your help the FMA has gained two additional representatives to the AMA House of Delegates in 1983. Bringing our total representatives to ten is a result of increased AMA membership in 1982.

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is the presenting
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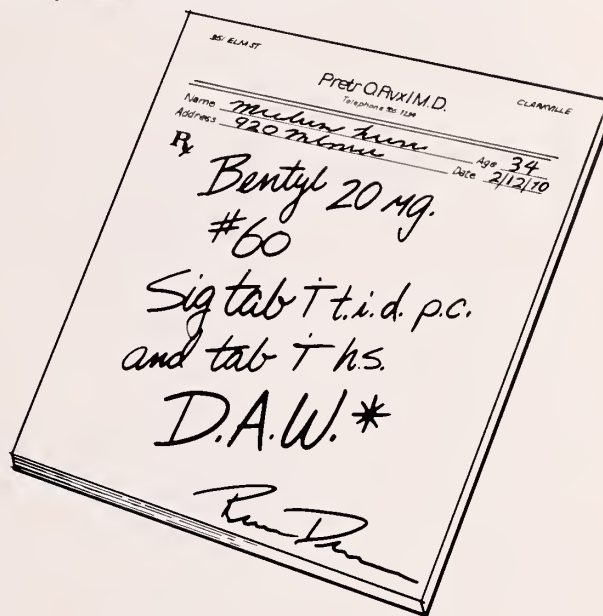


...in the functional bowel/irritable bowel syndrome*

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(dicyclomine hydrochloride USP)

10 mg capsules, 20 mg tablets,
10 mg/5 ml syrup, 10 mg/ml injection



**D.A.W.-Dispense as written*

because:

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- ⊕ At Merrell Dow, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- ⊕ Bentyl bioavailability of tablets, capsules, syrup and injectable is evidence of its prompt absorption.
- ⊕ Bentyl helps control abnormal gastrointestinal motor activity with minimal anticholinergic side effects. (See Warnings, Contraindications, Precautions, and Adverse Reactions on next page.)
- ⊕ The bioequivalence of the oral dosage forms permits a choice of tablet, capsules, or syrup that satisfies patient's dosage preferences.
- ⊕ Significant pharmacologic effect in the distal colon compared to placebo,¹ shows how Bentyl controls abnormal motor activity in the irritable colon patient.*

*This drug has been classified "probably" effective for this indication.

Merrell Dow

Reference:

1. Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

Although the dose of Bentyl used to show pharmacologic effect was 50 mg, which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg (2 ml) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl[®]

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the following indications as "probably" effective

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy), obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia, urinary hesitancy and retention; blurred vision and tachycardia; palpitations, mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.

DOSEAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg capsule and syrup: Adults: 1 or 2 capsules or teaspoonfuls syrup three or four times daily. Children: 1 capsule or teaspoonful syrup three or four times daily. Infants: 1/2 teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg: Adults: 1 tablet three or four times daily.

Bentyl Injection: Adults: 2 ml (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine* (bethanecol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by

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Swiftwater, Pennsylvania 18370 or

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Miracle of a Child

Why is Christmas, so universally, such a well beloved holiday? Is it because of the tradition, the festivities, the religious heritage, the family gatherings or the memories of the Happy Christmases of one's childhood? Could it be St. Nicholas, the legendary figure of this holiday season, shared by all faiths, a bearer of good will to all children, leaving a trail of happiness wherever he visits? Could it be the gifts and the giving which require no special talents nor large amounts of money but love sharpened with imagination, an act compounded of the heart and the head as a means of expressing one's feelings? And as the true gift is a portion of one's self, is it the amount of one's self one puts into it?

Rather is it not that Christmas, more than just a date on the calendar, is the festival of all children everywhere and the celebration of the birthday of a Child whose influence lives on, uplifting standards of action and thought, inspiring laws, enlisting the strong in service to the needy and weak. Symbolized by the birth of a child, always truly a miracle; with child-like faith, Christmas is a state of the heart, a day that brings hope into all the world and a time for understanding, a time for sharing, and a time for children. Children see so clearly through the tinsel and the habit and the earthly to the love which in them, strains eternally for expression. Children are truly important people of the earth and in cradles everywhere and at the foot of Christmas trees this season are those who are to overthrow and rebuild all that we have ever built. Nothing is so powerful or so perfect that it cannot be transformed utterly by the miracle of a child.

An old fable tells of how, on Christmas Eve, an enchantment falls upon the earth and the spirit of a newborn child whose name is love, possesses the world. The way to Christmas lies through an ancient gate, patterned after a sheepfold and guarded by angels with stardust in their hair. It is a little gate, child-wide and child-high and there is a password: "Peace on earth to men of goodwill." May we on Christmas, once again become as little children and enter into this kingdom.

Christmas can never be looked at properly with a cold, practical eye for its true worth is that at Christmastide, real values come more clearly into focus, giving occasion to take time out of one's busy life to express gratitude for friends and the material things of life and commemorate Christmas, by seeking

Him, whose lessons of humility, compassion, sacrifice and love 2,000 years ago were never clearly heard, yet never really forgotten.

But you can never celebrate Christmas with bitterness in your heart.

C.M.C.

"Peace on Earth"

*Happy is he who bears a god within himself,
an ideal of beauty, and obeys him:
an ideal of art, an ideal of science,
an ideal of the nation, an ideal of the
virtues of the Gospel. These are the living
springs of great thoughts and great actions.
All are illuminated by reflections of the infinite.*

So said Louis Pasteur on his reception into the Academie Francaise, April 27, 1882.¹ In this season when men's hearts turn to thoughts of "Peace and good-will towards men," so let us reflect on our heritage and responsibilities in medicine. The practice of medicine offers unique opportunities for insights on the human condition. It offers us the opportunity to show kindness and understanding to those persons in time of tragedy, sickness, birth, death as well as ordinary times.

The Christmas season commemorates a time God joined man to try to attain the highest ideals of both. Whether we view this in a literal or a mythic sense, the Christmas message comes down to us again, "Peace and good-will towards men."

F.N.V.

1. Quoted in Familiar Medical Quotations, Maurice B. Strauss, ed. Little, Brown and Co., Boston 1968 p. 490





Rx for fine dining.

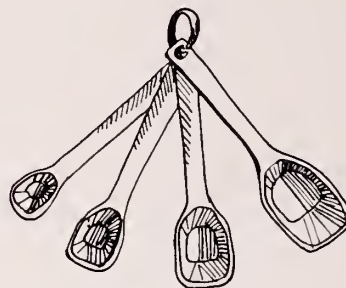
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KEY LIME PIE

"This tried and true recipe is best with a graham cracker crust. It's easy and can be done ahead!"

4 egg yolks, well beaten	1/2 tsp. cream of tartar
1 can sweetened condensed milk	3/4 cup sugar
1/2 cup lime juice (4-6 limes)	1 9" graham cracker pie shell, baked
6 egg whites*	

In a small mixing bowl beat egg yolks until lemon-colored. Blend in condensed milk. Add lime juice, mix well. In a large mixing bowl beat egg whites and cream of tartar until foamy. Continue beating, adding sugar 1 tablespoon at a time until egg whites peak. Fold 6 tablespoons of meringue into the filling mixture. Pour into pie shell. Top with golden brown. Bake in a slow 330°F oven for about 30 minutes or until golden brown. Best served chilled. May be frozen and kept for a couple of days before serving.

*You can make the meringue with only 4 egg whites from the eggs you've used

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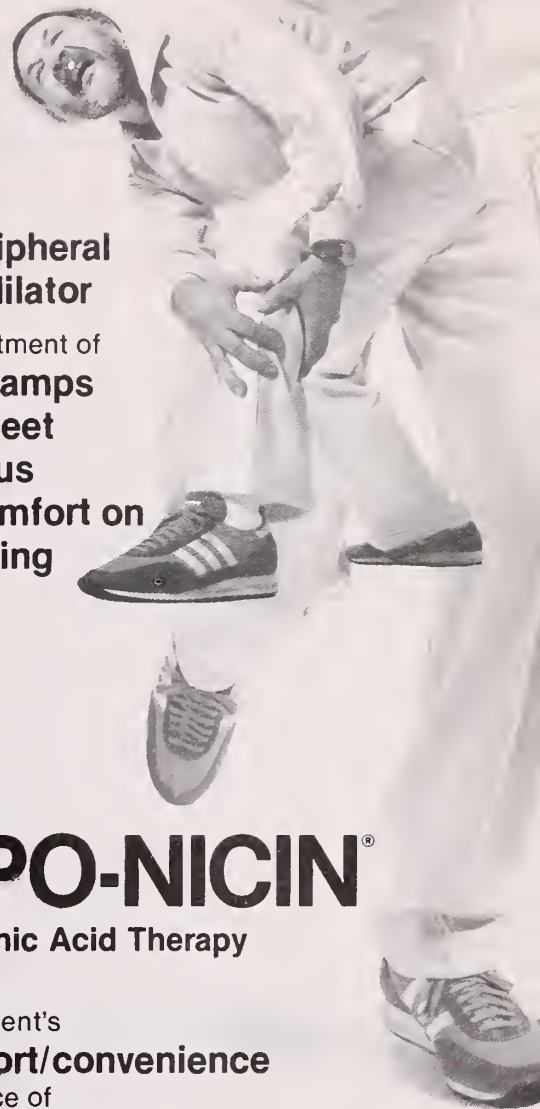


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Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 3 tablets daily.

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LIPO-NICIN[®]/100 mg.

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Niacinamide 75 mg.
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Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

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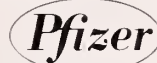
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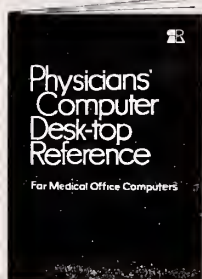
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Primary tumors of the liver in infancy and childhood

Farhat Moazam, M.D.; James L. Talbert, M.D., and Bradley M. Rodgers, M.D.

ABSTRACT: A review is presented of 17 children with primary tumors of the liver. Of eight children with primary benign tumors of the liver, five underwent successful resection. Two infants with refractory congestive heart failure secondary to diffuse benign hepatic hemangiomas unamenable to resection required hepatic artery ligation for management with prompt relief of their symptoms postoperatively. One infant with diffuse benign hemangioendothelioma of the liver underwent malignant transformation of the lesion and succumbed within three months of diagnosis with metastatic disease. Among the nine children with malignant neoplasms, four presented with hepatoblastomas and, following successful resection, are alive to date. There was minimal postoperative morbidity. In contrast, the children with primary hepatomas of the liver fared poorly. They formed a distinctive group of older patients with their disease too extensive to allow curative resection at the time of exploration. All were dead within four months of diagnosis. Preoperative attempts to distinguish the primary benign liver neoplasms from their malignant counterparts remain a problem, and histological examination continues to be the most accurate method of establishing the diagnosis. Exploration and liver biopsy are essential, with complete resection if possible.

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Primary neoplasms of the liver comprise 15% of all abdominal tumors¹ and 2% of all solid malignancies in infants and children.² The role of surgery in the management of neoplasms of the liver has been of recent advent, the first successful resection of a hepatoblastoma in a child being reported in 1952.³ Since then, several reports have confirmed the safety of major hepatic resection in children. The following experience with 17 children with primary neoplasms of the liver, who presented to the Pediatric Surgical Service of the University of Florida from 1969 to 1979, emphasizes several unique aspects of these tumors and identifies the factors important in their successful management.

Clinical experience • Among the 17 children, eight, aged five weeks to four years ten months, presented with benign liver tumors (Table 1). Five were female. Six presented with asymptomatic hepatomegaly detected during routine examination by a pediatrician or else noticed by an observant parent. The oldest child in the group complained of mild, diffuse lower abdominal pain for approximately six to eight months. Two infants (Cases 7 & 8, Table 1) presented with congestive cardiac failure, hepatomegaly and multiple cutaneous hemangiomas distributed over the entire body. In both patients a bruit was audible over the liver. All eight children were anemic with hematocrits ranging from 29% to 34%. Liver enzyme determinations were within normal limits. Technetium liver scans obtained in seven patients revealed solitary or multiple filling defects. Abdominal sonography confirmed the presence of the lesion in the liver in six patients but in one was erroneously interpreted as being a large mesenteric cyst. Among the eight

TABLE 1.
BENIGN HEPATIC TUMORS

CASE	SEX/RACE	AGE AT DIAGNOSIS	OPERATION	PATHOLOGY	OUTCOME
1.	M/W	21 mo.	R hepatic lobectomy	Mesenchymal hamartoma	Well—2 yrs.
2.	F/B	4 & 10/12 yrs.	R hepatic segmentectomy	Mesenchymal hamartoma	Well—6 mo.
3.	M/W	6&1/2 mo.	R hepatic lobectomy	Hamartoma	Well—4 yrs.
4.	M/B	6 & 1/2 mo.	Extended R hepatic lobectomy	Infantile hemangioma	Well—1 yr.
5.	F/W	6 mo.	R hepatic lobectomy	Benign hemangioendothelioma	Expired—3 mo. following diagnosis*
6.	F/B	5 wks.	R hepatic lobectomy	Benign hemangioendothelioma	Well—1 yr.
7.	F/B	3 mo.	Ligation of both hepatic arteries and mammary vessels; liver biopsy	Diffuse hemangiomas	Well—8 mo.**
8.	F/W	3 mo.	Ligation of both hepatic arteries; liver biopsy	Benign hemangioendothelioma	Well—1 yr.**

*Autopsy: Grade II hemangioendothelioma

**Off all medications

children, seven underwent selective arteriography and four studies were interpreted as showing characteristics of malignant tumors. (Fig. 1)

All eight patients with benign tumors of the liver underwent exploratory laparotomy for diagnosis and management. Three children were found to have hamartomas limited to the right lobe



Fig. 1—Hepatic arteriogram demonstrating a large intrahepatic mass supplied mainly from the branches of the right hepatic artery. The appearance was believed most likely to represent a hepatoblastoma.

of the liver and amenable to a right hepatic lobectomy (Fig. 2). Of the five patients with primary tumors of a vascular origin, two had infantile hemangiomas, whereas the histology in three was consistent with benign hemangioendothelioma. In two children, the hemangioendothelioma and hemangioma were limited to the right lobe and were resected successfully by means of a right hepatic lobectomy and an extended right hepatic lobectomy, respectively. Two children presented with a clinical picture of hepatomegaly and severe congestive heart failure refractory to intensive therapy with digoxin and furosemide. High doses of systemic steroids were employed unsuccessfully, and one child received low dose radiation to the liver in an attempt to control the high output cardiac failure. When these conservative measures proved unsuccessful, both infants underwent hepatic artery ligation with prompt relief of their symptoms postoperatively. In one patient, concomitant bilateral ligation of internal mammary vessels was required to interrupt direct communication with the intrahepatic hemangiomas. A third child with massive hepatomegaly resulting in increased intraabdominal pressure but with no evidence of congestive failure underwent exploratory laparotomy for creation of a ventral hernia. Liver biopsies were obtained from multiple sites and revealed diffuse benign hemangioendothelioma not conducive to curative resection. Subsequently her lesions progressed rapidly, despite radiation to the liver and high doses of systemic steroids, and she succumbed to liver failure two months following laparotomy. At autopsy, her entire liver was found



Fig. 2—Appearance of the neoplasm arising from the right lobe of the liver at the time of surgery. Pathological diagnosis: benign mesenchymal hamartoma.

replaced by the tumor. Multiple sections from the involved liver revealed an aggressive, grade II hemangioendothelioma, a finding which contrasted significantly with the benign histology of the liver biopsies obtained at surgery. In addition, metastatic tumor was found in the small bowel serosa as well as in the left adrenal gland. All other children with benign tumors are alive, with the longest follow-up period being four years.

Nine patients, five males and four females, presented with primary malignant neoplasms of the liver (Table 2). The ages of these patients ranged

from three months to 18 and one-half years. Four patients were noted to have hepatoblastomas (Figs. 3 & 4) and presented under five years of age, with the youngest patient three months old at the time of diagnosis. This was in marked contrast to the five children with hepatocarcinoma and hepatosarcoma, where four of the patients were greater than ten years of age at the time of diagnosis. All patients with hepatoblastoma presented with progressively enlarging, asymptomatic abdominal masses with normal liver function tests. One patient was anemic, with a hematocrit of 23% (Case 1, Table 2). One of the two patients with hepatocarcinoma had a history of long-standing postnecrotic cirrhosis (Case 5, Table 2). One patient with a hepatosarcoma (Case 8, Table 2) had had a benign hepatic cyst resected in the past. All five patients with hepatocarcinoma and hepatosarcoma appeared debilitated at the time of presentation in contrast to the group of children with hepatoblastomas. All children were anemic, whereas three children (Cases 5, 6 & 7, Table 2) revealed deranged liver function tests and abnormal coagulation profiles. In six patients with primary malignant hepatic tumor, technetium scans revealed solitary or multiple filling defects. Selective arteriography was obtained in six patients to define the location and extent of the tumor. In each study, a suspicion of malignancy was entertained preoperatively based on the arteriographic findings. All hepatoblastomas were located in the right lobe of the liver, whereas the hepatocarcinomas and

TABLE 2
PRIMARY MALIGNANT HEPATIC TUMORS

CASE	SEX/RACE	AGE AT DIAGNOSIS	OPERATION	PATHOLOGY	OUTCOME
1.	M/W	3 mo.	Extended R hepatectomy	Hepatoblastoma	Recurrence R Lung 8 yrs. following resection
2.	FW	2 & 1/2 yrs.	R hepatic lobectomy	Hepatoblastoma	NED—5 yrs.
3.	M/W	3 & 8/12 yrs.	R hepatic lobectomy; postoperative chemotherapy	Hepatoblastoma	NED—2 yrs.
4.	M/W	4 & 7/12 yrs.	R hepatic lobectomy	Hepatoblastoma	NED—6 mo.
5.	M/W	12 & 3/12 yrs.	Multiple liver biopsies	Postnecrotic cirrhosis with hepatocarcinoma	Expired—3 mo. following diagnosis
6.	M/W	4 mo.	Multiple liver biopsies	Hepatocarcinoma	Expired—1 day following surgery
7.	FW	11 & 9/12 yrs.	Palliative L hepatic lobectomy; postoperative chemotherapy	Undifferentiated sarcoma	Expired—3 mo. following diagnosis
8.	FW	10 & 8/12 yrs.	Multiple liver biopsies	Undifferentiated sarcoma	Expired—1 mo. following diagnosis
9.	FW	18 & 8/12 yrs.	Multiple liver biopsies	Hemangiosarcoma	Expired—1 mo. following diagnosis



Fig. 3—Hepatic arteriogram demonstrating a large tumor mass in the right lobe of the liver supplied by the right hepatic artery. Appearance consistent with a hepatoblastoma.

hepatosarcomas involved both lobes diffusely.

All nine patients with primary malignant neoplasms of the liver underwent exploration. Preoperative arteriography helped in delineating the extent of the tumor and enabled a preoperative decision concerning the resectability of the tumor. All four hepatoblastomas were resected successfully by means of right hepatic lobectomies. No evidence of spread beyond the liver was present at the time of surgery and, despite major hepatic resection, there was minimal postoperative morbidity and no postoperative mortality. One child (Case 3, Table 2) had microscopic extension of the tumor to the line of resection and received postoperative chemotherapy consisting of vincristine, cyclophosphamide, 5-fluorouracil and doxorubicin hydrochloride. He remains free of disease three years later. Another child (Case 1, Table 2), however, with a completely resected hepatoblastoma developed recurrent tumor in the mediastinum with secondary hilar involvement eight years later and is at present on chemotherapy and irradiation. The remaining two patients with hepatoblastoma are alive and disease free from six months to four years following resection. In contrast, the children in the hepatoma group did poorly. Two children (Cases 5 & 6, Table 2) were diagnosed as having hepatocarcinoma and, at exploration, the disease in each was too extensive to allow resection. Due to the extent of the disease, no adjunct therapy was felt to be indicated. Both children died within three months of diagnosis. Three children had extensive hepatosarcoma at the time of exploration, one with diffuse hemangiosarcoma (Case 9, Table 2) and two with undifferentiated sarcoma. In each, the disease had spread beyond the liver and was not conducive to

curative resection. In two children with hepatosarcoma, only a diagnostic biopsy of the liver was performed, whereas palliative left hepatic lobectomy was performed in the third patient (Case 7, Table 2). Two children received postoperative chemotherapy but all three succumbed within three months of diagnosis.

Discussion • In 1974 a survey of the Surgical Section of the American Academy of Pediatrics accumulated 375 primary liver tumors in children.⁵ This was the first report presenting a large number of such patients and provided important information about the nature, diagnosis, treatment and prognosis of these neoplasms. The patients in our report exemplify this experience and emphasize several unique aspects of primary hepatic neoplasms in children. Approximately a third of all primary liver tumors in childhood are benign and, among these, the most common appear to be of a vascular origin.⁶ As seen in our group of patients, most vascular tumors are noted in the first year of life. Similar to their counterparts on the body surface, hemangiomas of the liver tend to grow rapidly initially and subsequently undergo spontaneous regression. During the period of rapid growth, they can produce significant symptoms including thrombocytopenia and intractable congestive cardiac failure.⁷ Due to the extensive intrahepatic arteriovenous shunting, these infants have a high output cardiac failure which is exceedingly difficult to control with medical management. Large doses of systemic steroids have been used in an attempt to produce regression of these tumors and some success has been reported.⁸⁻⁹ Radiation to the liver has also been employed for a similar purpose. Park and Phillips reported good control in four out of five patients after administering 1200 to 1500 rads to the entire liver; however, only one of their patients was an infant.¹⁰ Consequently, some form of surgical intervention becomes necessary to control the deteriorating clinical picture. Hemangiomas or hemangioendotheliomas limited to one hepatic lobe can be resected with an acceptable morbidity and mortality. Difficulties arise, however, when the process is diffuse with no possibility of a complete resection. In 1967 DeLorimier reported successful management of congestive cardiac failure secondary to hepatic hemangioma in an infant following hepatic artery ligation.¹¹ Another case was reported in 1976 by Laird who successfully managed a similar problem in a two month old infant.¹² We have had the occasion to use this technique on two infants with excellent postoperative results. Within six to eight weeks following hepatic artery ligation, both infants were off digoxin and had undergone an impressive decrease in the size of their livers.

It is not always possible to predict the natural progression of infantile hemangioendotheliomas. In 1971 Dehner and Ishak reported primary vascular tumors of the liver in children and stressed that, although considered benign, infantile hemangioendotheliomas are associated with a high mortality.⁷ All of their patients in congestive cardiac failure died within a few weeks after diagnosis, whereas malignant behavior with eventual metastases developed in the tumor of one patient. The aggressiveness of hemangioendothelioma of the liver is illustrated by one of our patients (Case 5, Table 1) who succumbed to liver failure after progressive replacement of her entire liver with the infantile hemangioendothelioma. Histology at autopsy revealed conversion of the benign tumor to an aggressive grade II hemangioendothelioma as described by Dehner.⁷ Metastatic deposits of this tumor were evident in the left adrenal gland as well as the serosal surface of the small intestine. In view of their potential for malignant degeneration, benign hemangioendotheliomas require an aggressive surgical approach with complete resection if anatomically feasible.



Fig. 4—The neoplasm arising from the right hepatic lobe. Pathological diagnosis: hepatoblastoma.

Considerable difficulty is encountered in distinguishing benign tumors of the liver preoperatively from their malignant counterparts. Most primary liver tumors, benign or malignant, present in children under two years of age as asymptomatic masses noticed by an astute pediatrician or watchful parents.¹³ In older children, anorexia and some weight loss may be evident. The laboratory data are not helpful in the preoperative differentiation of these tumors. Anemia may be evident in only 50% of patients with malignant tumors and the liver enzymes are infrequently elevated except in children with hepatocellular carcinoma. Alpha

fetoprotein levels are elevated in two thirds of patients with hepatoblastoma and 40% of children with hepatocarcinoma⁵ and may prove to be an important preoperative study in children suspected of harboring liver tumors. Among radiographic studies, abdominal sonography and technetium liver-spleen scans are nonspecific except for confirming the presence of a lesion in the liver. Selective arteriography continues to remain the most valuable test.¹⁴ With progressive expertise, this can be obtained in small infants with minimal morbidity. However, this procedure is not infallible in distinguishing conclusively the benign tumor from the malignant variety.¹⁵ In our series, four patients believed to have malignant tumors on the basis of preoperative selective arteriograms were found to have benign hepatic lesions on exploration. Histological examination remains the most accurate method of establishing the malignant potential of live neoplasms and, therefore, exploration and liver biopsy are essential with complete resection preferred if possible.

Among the primary malignant liver tumors, hepatocarcinoma and hepatosarcoma seem to form a clinically distinguishable group.⁵ These tumors appear to be less common, the children are often older at the time of presentation and the disease is frequently advanced at the time of diagnosis. All five children with these tumors in our group had advanced disease which was not amenable to curative resection. None survived beyond four months after exploration. This dismal outlook is confirmed by other authors reporting survival rates of less than 30% after surgical resection.⁵

In contrast, hepatoblastoma, the most common primary malignant tumor of the liver in childhood, appears to have a better prognosis. Males are affected more frequently than females and the majority of patients are under five years of age at the time of diagnosis.^{5,14} Although most tumors are greater than five centimeters in diameter at the time of diagnosis, an overall 60% cure rate is reported with wide surgical resection. With expert anesthesia and meticulous surgery, postoperative morbidity and mortality have been reduced to an acceptable level. Among the four children who underwent hepatic resection for hepatoblastoma at our institution, there were no operative deaths. The role of adjunct chemotherapy and irradiation in improving survival in these patients remains to be established. Sporadic reports in the literature attest to initially unresectable hepatoblastomas responding to chemotherapy and irradiation, allowing delayed resection and long-term survival.¹⁶ Late recurrences following adequate resection of hepatoblastoma also remain a problem. Ein reported recurrence in a patient five years after resection of a hepatoblastoma,¹⁴ whereas one of our patients returned with recurrence of the tumor in

the mediastinum eight years after complete resection of a stage I hepatoblastoma. These cases emphasize the need for careful follow-up for extended periods after resection. Until data are provided otherwise, early diagnosis and aggressive surgical resection still appear to offer the best chance for cure in primary malignant liver tumors in children.

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Medical and public health consequences of nuclear war on the State of Florida

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ABSTRACT: Based on estimates provided by the Office of Technology Assessment, selective deployment of approximately 2% of the currently estimated Soviet nuclear arsenal at major urban areas in the State of Florida would result in the immediate death of approximately 60% of the population. The majority of the surviving population would be acutely injured. Ignoring the high risk location of most health care personnel, there would be a minimum of several hundred acute injuries for each surviving physician and as many as 1000 injured individuals for each remaining hospital bed. If the effects of physician injury and distribution, disruption of transportation and communication and the delayed complications resulting from radiation sickness, infection, starvation, and genetic damage are considered, the magnitude of these projections is even greater. Even adjusting for optimal conditions related to ambient weather, individual sheltering and the timing of attack, no meaningful medical or public health intervention will be possible in the State of Florida in the event of a nuclear war.

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There is renewed interest in the role of civil defense and the response of the health care system in the event of a nuclear conflict involving the United States. It is imperative that health professionals become aware of the possible medical and public health consequences of nuclear war.¹⁻⁴ It is also important that the knowledgeable physician play an active role in informing public officials about such consequences and what potential exists for a substantial response by the health care system.^{5,6} The medical effects of a nuclear attack can be divided into immediate blast injuries, effects of nuclear fallout and delayed consequences of radiation exposure.^{1,7} The public health effects would include destruction of large numbers of available health care personnel and facilities, creation of a fertile environment for communicable disease, and disruption of transportation and social organization as it currently exists.^{4,6,7}

This report represents a summary of the potential medical and public health consequences of nuclear war on the State of Florida. Utilizing a model based on available government projections, the consequences of nuclear war would make any meaningful medical or public health preparation impossible.

Methods • Current population and facility estimates were obtained from the 1981 Florida Statistical Abstracts.⁸ Strategic forces estimates were derived from the Annual Report of the Secretary of Defense (FY 1981). Morbidity and mortality estimates were obtained from documents provided by the Office of Technology Assessment and the United States Arms Control and Disarmament Agency.^{9,10}

The immediate effects of nuclear war on the general population and available health care resources are those prompt consequences of the mechanical

pressure and of the thermal and nuclear radiation products associated with the detonation of a nuclear device. The lethal area is considered to be a circular area around ground zero within which the number of survivors will equal the number of fatalities outside the circle assuming a uniform population density.¹

The delayed effects of nuclear war on the population consist of the subsequent results of an explosion such as fires and fallout which depend to a much greater extent on prevailing weather conditions and the level of protection available. Flashfires and firestorms increase in likelihood with multiple detonations, may greatly extend the region of destruction, and make shelter efforts useless.⁷ Fallout consists of condensation of heat-produced by-products. Its effects are related directly to the intensity and duration of exposure. The distribution of fallout particles is largely determined by the yield of the nuclear weapon, height of detonation and prevailing weather conditions.

Delayed effects also include the medical complications resulting from blast, thermal and radiation exposure in the surviving population including extensive burns, infection, radiation sickness, and myelosuppression.^{2,4} Simulation studies suggest that in the post-attack period, upwards of one fourth of the survivors might die of acute communicable disease alone with 6% dying of plague.⁴ While accurate estimates are difficult, it is likely that upwards of two thirds of the injured survivors in a nuclear exchange would die in the subsequent weeks and months.⁵

Long-term effects, such as malignancy and genetic defects, are real but depend heavily on the degree and duration of exposure making accurate prediction of risk difficult.

The nuclear threat • Estimates of the strength of Soviet strategic forces capable of use against the United States in a nuclear war by 1985 are summarized in Table 1. While the targets of these devices are not known precisely, there is no doubt that, in addition to known military targets, a substantial proportion will be directed toward urban civilian areas. While the State of Florida has less industry than much of the northeastern United States, it contains three strategic air command bases and three tactical air command facilities, as well as at least one weapons production plant. These facilities, along with the

highly concentrated civilian population, make Florida a likely target for a substantial proportion of the weapons directed at the United States.

Immediate effects • Population effects - In addition to massive strikes directed at military targets, it has been estimated that 2000 to 2500 Soviet weapons would be directed at populated urban areas in the United States during a full scale nuclear exchange.⁹ While there are many ways in which the Soviet nuclear arsenal could be distributed, it is anticipated that such weapons would be deployed in proportion to the population of specific urban areas. For purposes of analysis, it is proposed that a representative distribution of 2000 to 3000 Soviet warheads directed at United States urban areas might consist of (a) the equivalent of two 20 megaton bombs for metropolitan areas with more than 250,000 population; (b) two one megaton warheads for those with populations between 75,000 and 250,000 and (c) a single one megaton bomb for areas with populations between 25,000 and 75,000 population. This estimate of a nuclear strike directed at the populated areas of the State of Florida has a total yield of 217 megatons which represents 8% of the anticipated Soviet arsenal directed at the United States urban areas or 2% of the projected total Soviet nuclear capability.

Table 2 summarizes available estimates of death and injury in the major metropolitan areas of the State of Florida resulting from the immediate effects of a nuclear strike of modest size. The United States population estimates are based on central urban populations which constitute 59% of the current population of the state. Based on these conditions, it is estimated that 92% of the central urban population of the state would die as an immediate consequence of the nuclear strike.

Estimates of the population of the metropolitan statistical areas (MSAs) centered around each major urban area are also provided. The population of the MSAs accounts for 88% of the state's total population and represents a more realistic estimate of the number that will be exposed to the immediate effects of a nuclear strike. For purposes of these estimates, it has been assumed that no additional immediate deaths will occur in the surrounding metropolitan area. However, a substantial proportion of this population, perhaps approaching 80% of the surviving population of the state, may be injured.

Table 1. — Estimated Soviet Nuclear Arsenal ^a

Vehicle Type	Number	Warheads	Yield (Megatons)
Land Based Missiles	1398	6654	7131
Sea Based Missiles	900	1500	780
Aircraft	140	140	2200
TOTAL	2438	8294	10,111

Effects on health care resources — It is more difficult to estimate the effects of a nuclear attack on existing health care personnel and facilities. The major difficulties include the varying distribution of health care facilities within metropolitan areas and the flux of health care personnel within these areas dependent on the day of the week and the time of day.

Table 2. — Early Effects Of A Nuclear Attack

Population Estimates

	U.S. Estimates ¹⁰	MSA ⁸	Deaths ¹⁰	Injuries ¹⁰
Group I+				
Miami-Ft. Lauderdale	2,320,000	2,640,000	2,005,000	231,000- 551,000
Tampa-St. Petersburg	1,047,000	1,567,000	1,035,000	10,000- 530,000
Jacksonville	547,000	738,000	542,000	5,000- 196,000
Orlando	407,000	701,000	404,000	3,000- 309,000
W. Palm Beach	358,000	573,000	340,000	13,000- 228,000
Group II++				
Sarasota-Bradenton	224,000	350,000	189,000	29,000- 155,000
Pensacola	182,000	290,000	159,000	19,000- 127,000
Daytona Beach	126,000	259,000	119,000	5,000- 138,000
Tallahassee	95,000	160,000	93,000	2,000- 67,000
Gainesville	88,000	151,000	85,000	3,000- 66,000
Lakeland	84,000	322,000	81,000	3,000- 241,000
Group III+++				
Ft. Myers/Cape Coral	64,000	205,000	56,000	6,000- 147,000
Ft. Walton Beach	51,000	110,000	50,000	1,000- 60,000
Ocala	49,000	122,000	48,000	1,000- 74,000
Panama City	48,000	98,000	45,000	3,000- 53,000
Melbourne	46,000	273,000	37,000	7,000- 243,000
TOTAL	5,736,000	8,559,000	5,288,000	341,000- 3,185,000

+ Two 20 megaton nuclear bombs

++ Two 1 megaton nuclear bombs

+++ One 1 megaton nuclear bomb

Table 3 provides minimum estimates of the effects of a nuclear strike on the number of available general hospital beds and practicing physicians in the MSAs. The calculated losses would be substantially greater if the central urban location of most municipal hospitals was considered and if the postulated nuclear strike occurred at a time when most physicians are in their offices or hospitals.

Reference to Tables 2 and 3 indicates that, even if we make the unrealistic assumption that all surviving physicians can deliver effective emergency aid, for every available physician there will be from 300 to 3000 acutely injured survivors. In addition, for each remaining hospital bed, there will be several hundred acutely injured survivors.

Delayed effects • The anticipated delayed effects of a nuclear attack are much more difficult to estimate since they depend on such factors as the number, type and site of weapon detonation, ambient weather conditions and day and time of attack. If one assumes an average wind velocity of approximately 10 mph, the dose rates and accumulated doses of radioactivity from fallout at various distances from the site of detonation can be estimated. From these estimates, the area covered by a given accumulated dose of fallout radioactivity can be calculated. Taking into account the lethal effect of radiation based on the rate

and time distribution of the dose, the area over which an unprotected individual would have a 50% chance of lethal irradiation can be estimated.⁷ Based on these assumptions, the area in which the number of survivors would be equal the number of fatalities outside the area i.e., the lethal area, would be approximately 655 square miles for a one megaton blast and more than 10,000 square miles for a 20 megaton bomb. Under these typical environmental conditions, the ten 20 megaton and seventeen 1 megaton bombs directed at the State of Florida could lethally contaminate in excess of 110,000 square miles and potentially the entire population could sustain lethal effects from fallout. Some survivors would be anticipated on the basis of the nonuniform distribution of attack sites, overlap of the distribution paths of fallout particles, and shelter preparations of varying scales.

Lowered resistance to infection, inadequate medical supplies and personnel and disruption of communication and transportation will place the surviving population at inordinate risk for overwhelming infection and widespread epidemics. Table 4 provides estimates of the incidence and mortality associated with acute epidemic disease among survivors. These simulations suggest that, in the absence of other causes of death, over 40% of exposed survivors could die of acute epidemic infections in the post attack-period.

Discussion • Increasing public awareness of the possibility of a major nuclear exchange makes it imperative that the medical consequences of such an attack be examined carefully. In addition, suggestions that elaborate civil defense and medical preparedness programs are necessary to enhance the potential for survival and recovery from a nuclear attack make it essential that the public health consequences be considered.^{6,11}

Even the most conservative estimates indicate that in excess of 2000 weapons could be directed at civilian population centers in the United States during a nuclear attack. With its rapidly increasing economic base, strategic military importance, and concentrated population centers, the State of Florida would be a prime target for a large number of warheads. Based on estimates provided by the Office of Technology Assessment and national population statistics, it is suggested that the state will receive approximately 8% of the Soviet population-directed force in such an exchange.

Based on the results of simulation studies provided by the U.S. Arms Control and Disarmament Agency, it is estimated that approximately two thirds of the population of the state would die as an immediate consequence of such a nuclear attack. Anywhere from 10% to 80% of the surviving population would sustain blast, thermal or radiation injury sufficient

to partially or completely incapacitate them. Based on generous distribution assumptions, it is estimated that from 2000 to 3000 injured survivors would exist for every surviving physician, the majority of whom would have been acutely injured or irradiated themselves. It is unlikely that even extensive civil defense efforts would reduce significantly the number of acutely injured and available health care capabilities would be immediately overwhelmed.

The delayed effects of nuclear war are more difficult to estimate due to the importance of the type and timing of the attack as well as ambient weather conditions. Based on the projected nuclear strike on the state and fairly typical weather conditions, the cumulative lethal area from the separate detonations would be approximately twice the entire area of the state. Therefore, it is likely that the vast majority of the survivors of the immediate effects of the attack would subsequently be exposed to lethal doses of radiation. Overlapping target areas, variations in weather patterns and shelter preparations might leave a minority of the surviving population with sublethal radiation exposure. However, the ubiquitous nature of post-attack radiation makes it unlikely that any planned evacuation effort will result in a substantial reduction in these estimates.

Table 3. — Early Effect of Nuclear Attack

Health Personnel and Facilities Estimates ^a

	Current		Remaining After Nuclear Attack	
	Hospital Beds	Physicians	Hospital Beds +	Physicians [°] +
Group I				
Miami-Ft. Lauderdale	17,030	5,327	2,312	723
Tampa-St. Petersburg	9,120	2,040	105	23
Jacksonville	3,365	907	31	8
Orlando	3,218	831	24	6
W. Palm Beach	2,418	751	122	38
Group II				
Sarasota-Bradenton	1,933	469	302	73
Pensacola	1,546	318	195	40
Daytona Beach	1,676	299	93	17
Tallahassee	853	226	18	5
Gainesville	1,673	597	57	20
Lakeland	1,806	326	65	12
Group III				
Ft. Myers/Cape Coral	1,138	247	142	31
Ft. Walton Beach	471	124	9	3
Ocala	359	126	7	3
Panama City	385	73	24	5
Melbourne	961	241	188	47
TOTAL	47,952	12,902	3,694	1,054

[°] Includes physicians injured in attack

+ Assumes distribution similar to civilian population

Survivors exposed to sublethal levels of radiation will be at increased risk of serious infection due to radiation effects, malnutrition, trauma, lack of sanitation, and confinement in shelters.⁴ In addition, the deficit of diagnostic facilities, antibodies, medical personnel and necessary methods of transportation will result in delayed and often inadequate infection control. The simulation studies presented here suggest that in excess of one third of the survivors may die of acute epidemic infections in the weeks following a nuclear attack.

Due to the extrapolations required, the long-term effects of a nuclear attack on cancer incidence and birth defects have not been projected. However, the Office of Technology Assessment has estimated that the number of deaths due to these causes throughout the United States following a nuclear war would be in the millions.¹⁰ That same study has concluded that while the long-term effects of nuclear war on the ecosystem are incalculable, the resulting damage may be as great as that resulting from the immediate effects of nuclear war.

As disheartening as these estimates appear, they clearly overestimate the number of survivors of a nuclear strike on the State of Florida. A substantially greater proportion of the Soviet nuclear arsenal than predicted may be launched against civilian areas. Attacks on military and industrial installations within Florida would add greatly to the total nuclear weapons directed at the state. A nuclear attack might occur at a time when the bulk of the working population, including physicians, is concentrated in the center of target areas. The estimates presented here also ignore the effects of ensuing firestorms and/or conflagration that may increase the immediate lethal area four or five fold.

The magnitude of the estimated public health problem is likewise grossly underestimated. It has been assumed that the surviving health care personnel will be adequately trained in emergency techniques, sufficiently healthy to provide care, willing to risk additional and perhaps lethal radiation exposure, and will have access to necessary transportation, medical supplies and paramedical assistance. In fact, diagnostic and therapeutic capabilities will be limited to crude first aid, the majority of physicians will be ill or dying, and simple necessities such as uncontaminated food, water and electricity will not be available. The public health impact would only appear greater by consideration of the effects of starvation, the survival advantage of rodents and insects carrying various infections, contamination of the environment by residual radiation and decaying corpses and the increased incidence of malignancy and genetic malformation that might be anticipated in long-term survivors.

To these estimates must be added the costs of preparing for a nuclear war with its diversion of limited

Table 4. — Estimated Number of Survivors With Acute Epidemic Diseases

Disorder	Incidence ⁴	Mortality ⁴
Amebiasis	34,000- 319,000	—
Influenza/Pneumonia	123,000- 1,147,000	6,820- 63,700
Food Poisoning		
Clostridia	191,900- 1,784,000	—
Staphylococcal	109,000- 1,019,000	—
Salmonella	140,000- 1,306,000	3,400- 31,900
Gastroenteritis		
Viral	201,000- 1,879,000	40,900- 382,200
Bacterial	167,000- 1,561,050	44,300- 414,100
Hepatitis	—	20,520- 191,000
Scarlet Fever	38,000- 350,000	—
Paratyphoid B	164,000- 1,529,000	6,800- 63,700
Plague	38,000- 350,000	17,100- 159,300
Shigellosis	85,000- 796,000	—

technical and financial resources away from medical care areas.¹²

Perhaps most sobering is the realization that in an actual nuclear war no outside assistance or relief will be forthcoming since the conditions described will prevail throughout much of the country and perhaps much of the world.

The impelling conclusion is obvious. A significant response of the health care system to such a disaster would be impossible. No amount of foresight or planning will provide conditions whereby a significant medical or public health response would be possible.¹³ We are faced with a holocaust beyond any prior experience or even comprehension. The only meaningful public health intervention that offers any possibility of success is that of preventing nuclear war.¹⁴

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Bacterial meningitis

A pediatrician's unusual encounters

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ABSTRACT: Three cases are presented of acute bacterial meningitis in infants. It is challenging to diagnose this disease in infants during the early stage when suggestive clinical symptoms, some positive physical signs, and misleading negative cerebrospinal fluid examination results are present. The importance of early diagnosis and prompt treatment is illustrated.

Each year in Plant City, Florida, a community of 17,000 people, an average of four cases of bacterial meningitis are diagnosed in the pediatric ward of the community hospital which serves a population of approximately 40,000. This report presents several unusual experiences with this disease.

Report of Cases • Case 1. — A one-month-old white male was seen for well-baby check-up on April 23. The mother stated that the baby was doing well and there had been no sign of illness since he was born uneventfully on March 19, weight 8 pounds 6½ ounces. The baby appeared healthy. The temperature was 103.8F, pulse rate 132/m, respirations 40/m, and weight 10 pounds 5 ounces. The remainder of the examination was unremarkable, including negative Brudzinski's sign and nonbulging fontanelle.

Because of fever the baby was admitted to the hospital. CBC revealed hemoglobin 12, hematocrit 35, white blood cell count 8,300 with 66% polymorphonuclear, 12% stab forms, 19% lymphocytes, and 3% monocytes. The result of urinalysis was negative and nose and throat cultures showed normal flora. Spinal fluid examination on the day of admission revealed: color, clear, protein 18 mg%, sugar 72 mg%, and no WBC seen. Spinal fluid and stool cultures gave negative results, also blood culture performed twice on the day of admission. Febrile agglutinins were negative and chest x-ray was within normal limits. The baby, observed closely for any developments, did not appear toxic in spite of remittent fever daily (highest temperature 105F). His appetite was good.

Repeat physical examinations continued to be unremarkable until April 25 when a small macular rash was noted on his face and lower extremities. The rash became petechial next day and viral infection was suspected. Close observation continued but antibiotics were not begun. On April 27 he became restless. His appetite was fair, the petechial rash remained the same and his general condition was the same. A third blood culture was taken and a spinal tap performed. This time the fluid was cloudy, protein 304 mg%, sugar 9.6 mg%, WBC 1,300/cu mm with 90% polymorphonuclear and 10% monocytes. A gram stain revealed two pairs of negative intracellular diplococci. Ampicillin 375 mg intravenously every six hours was instituted and the patient responded well. The second CSF culture subsequently grew *Neisseria meningitidis* but the third blood culture was sterile.

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He was discharged on May 7 in good condition and at three subsequent follow-up visits he showed normal growth and development.

Case 2. — A one-year-old white male was seen in the office on March 7 with chief complaint of fever and vomiting for two hours. The physical examination revealed no abnormalities except a temperature of 103.8°F. The pulse rate was 130/m, respirations 40/m, body weight 23 pounds 8 ounces. The CBC revealed hemoglobin 11, hematocrit 32, white blood cell count 13,000 with 71% polymorphonuclear, 8% stab forms 19% lymphocytes, and 2% monocytes. The patient was seen in the office again four hours later and at that time he appeared ill and was admitted to the hospital.

The chest x-ray and urinalysis were normal. Three hours later, physical examination revealed the patient to be toxic. The temperature was 104.8°F and tachypnea was noted. The neck was slightly stiff and Brudzinski's sign was demonstrated. Spinal tap was performed and the fluid was clear with 2 WBC/cu mm, protein 20 mg%, sugar 63 mg%, Cl 111 mEq/l. There was no organism seen on a gram stained smear or India ink preparation. Spinal fluid and blood cultures were ordered. The patient was given ampicillin intravenously for sepsis and next day he was no longer toxic, and the temperature had come down.

On March 9 both blood and spinal fluid cultures grew *Neisseria meningitidis*. The ampicillin was discontinued and penicillin 1 million units intravenously every six hours was instituted for ten days. The patient was discharged fully recovered.

Case 3. — An 11-month-old white male in apparent good health was put to bed on the night of December 10 as usual but next morning he was fussy and cried excessively. Subsequently vomiting, diarrhea, fever and lethargy developed. When seen in the emergency room he appeared somewhat toxic but well developed and well nourished, lethargic, but responded to the examiner. The temperature was 104.3°F, pulse rate 112/m, respirations 40/m, weight 21 pounds 13 ounces, blood pressure 90/50 mm Hg. The boy's head was normocephalic, the fontanelle was open and did not bulge. The mouth mucosa was slightly dry, the neck was supple. The Brudzinski's sign was demonstrable. There were two cavernous hemangiomas, one over the left chest wall and the other over the right buttock which was purplish in color, thickened and tender upon palpation. The remainder of the physical examination was unremarkable.

Complete blood cell count revealed hemoglobin 11.4, hematocrit 33, white blood cell count 3,900 with 19% polymorphonuclear, 48% stab forms, 24% lymphocytes, and 4% metamyelocytes. A spinal tap was done and the fluid was clear; there were no WBC seen. Sugar and protein were 68 mg% and 23 mg% respectively. The Cl was 127 mEq/l. Spinal fluid smear was negative for organisms. The chest x-ray showed no abnormalities.

After cerebrospinal fluid and blood cultures were performed, ampicillin 500 mg intravenously every six hours and chloromycetin 250 mg intravenously every six hours were started for sepsis and possible bacterial meningitis.

Next day the patient appeared improved and one day later cultures from CSF and blood grew group A beta-hemolytic streptococcus. Ampicillin and chloromycetin were discontinued and penicillin 500,000 units intravenously every four hours was given. The patient recovered with no complication.

Discussion • Because bacterial meningitis is a serious disease in the newborn and children, early diagnosis and treatment are of utmost importance.

In Case 1 meningococcal meningitis developed about one week beyond the neonatal period. The rareness of neonatal meningococcal meningitis¹ and this case's clinical manifestation (absence of toxicity and three consecutive negative blood cultures in four days) appear to favor the presumption of maternal transplacental antibody protection to the baby.² It is suggested that lumbar puncture should be done in 12 to 18 hours if a child with a normal CSF appears septic and meningeal signs develop.³ This patient did not appear septic and did not exhibit meningeal signs despite fever as high as 105°F and presence of several petechiae. It seems advisable, therefore, to repeat the lumbar puncture once or two days apart if a diagnosis has not been established in infants younger than two months old who have high fever but do not show significant clinical deterioration.

In Case 2 the negative physical examination in the office caused some doubt as to the location of the focus of infection. When the patient was seen four hours later, he appeared sicker and this prompted admission to the hospital for further work-up. Possibly more than one office visit on the same day can aid to either diagnose and treat the seriously sick pediatric patient promptly or to avoid hospitalization.

Similar to the report by Moore and his associates,⁴ Cases 2 and 3 had acute bacterial meningitis with misleading normal spinal fluid examinations (the appearance, cell count, chemistry studies, and smear for organism). Consequently, the importance of clinical judgment and reliance on culture/sensitivity of the spinal fluid are demonstrated.

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Premature mortality from diabetes

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The study of causes of death has been a traditional tool of the epidemiologist. Utilizing the death certificate, significant valuable information can be gleaned and many useful assessments are possible concerning the state of health. In addition, by focusing on certain subsets of the population, epidemiologists have been able to draw conclusions that extend beyond the deaths described. For example, infant mortality and/or maternal mortality are used to define aspects of health care and social hygiene conditions of more than infants and/or their mothers.

Total or crude mortality for a disease like diabetes has little analytic meaning. Simply put, for example, a person who has diabetes will die with the disease and, if he lives long enough, it could, perhaps, be expected to contribute to his ultimate demise. To conclude that, because a person dies with or from diabetes, the person did not have access to care or neglected to care for himself could be totally erroneous. The 70-year old who has diabetic renal failure after living 60 years with diabetes would be considered by many to be most fortunate to have survived so long with the disease.

To begin to approach chronic disease, epidemiologists have developed a concept of premature mortality; that is, mortality which could reasonably be considered to have occurred too soon given our understanding of the natural history of the disease process. Ultimately a premature death must be considered preventable. To better understand diabetes mortality a study of premature mortality appears indicated.

Methods, preliminary results and limitations of death certificates • Determining the age at which death from diabetes is premature is most

difficult. Diabetes has been recently recognized to be more than a single entity and currently has been divided into insulin dependent and non-insulin dependent types. Both types are recognized at all ages. Complications develop after a variable duration in both types. Therefore, to arbitrarily state that all deaths below a certain age are truly preventable would be unreasonable.

In addition, competing causes of death such as cancer and cardiovascular disease can further complicate an already difficult task, because competing causes may either raise or lower rates of diabetes deaths. The age at which a person who dies with diabetes should be considered premature also should be an age at which diabetes, if present, would likely be mentioned on a death certificate. With both the above-mentioned considerations taken into account, we and others have chosen 50 as the cutoff age for a premature death.¹

To conclude that, because a person dies with or from diabetes, the person did not have access to care or neglected to care for himself could be totally erroneous.

The death certificate itself provides a great deal of useful data. Social, demographic, place of residence and death, duration of terminal illness, and causes of death are all available. Certificates alone will provide age, race, sex, and residence (Table 1, Fig. 1). Certificates also yield an underlying cause of death (Table 2).

Death certificates alone will not allow a determination of duration, extent of complications or control of diabetes, nor an adequate assessment of the effect of diabetes on the terminal event. In addition, underlying cause of death from certificates has been shown to be unreliable.² Such information which can only be obtained through cooperation between physicians and the Department of Health and Rehabilitative Services (HRS) seems vital to a successful appraisal of premature deaths.

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Table 1.— Premature Mortality from Diabetes, 1981, Preliminary Summary Statistics from Death Certificates.

Number of Deaths by Age, Race and Sex

Age	White		Non white		Total
	Males	Females	Males	Females	
< 1	0	2	0	0	2
1-19	0	0	0	0	0
20-29	7	5	3	1	16
30-39	13	18	9	7	47
40-49	48	34	25	22	129
Total	68	59	37	30	194

Deaths occurred in 37 counties.

Deceased resided in 39 counties.

49% of deaths occurred in hospitals (in-patient).

27% of deaths occurred at home.

24% of deaths occurred in emergency rooms.

Medical Examiners certified 31% of deaths.

Proposed study • Proposed, then, is a study where all deaths in persons less than 50 years of age with diabetes will be investigated. Death certificates where diabetes is mentioned at all in any place on the certificate will be separated, photocopied, and sent to the Diabetes Program, Chronic Disease Section, Health Program Office, by the Public Health Statistics Section of the Office of Vital Statistics of HRS.

The certifying physician will be queried by letter and requested to participate in the study. If the physician was not the care provider but merely present at the death, the name of the primary physician will be sought and he will be invited to provide data about the patient's diabetes, treatment, and complications. In addition, pertinent data concerning control of diabetes will also be sought. Follow-up by phone call in order to maximize responses will also be done.

This proposed study has been reviewed and endorsed by the Health Program Office of HRS; American Diabetes Association, Florida Affiliate, Incorporated; Diabetes Advisory Council; the medical university-based Diabetes Education, Research, and Treatment Centers; as well as the Committee on Public Health of the Florida Medical Association.

Questionnaire for the study • The proposed questionnaire attempts to capture the necessary data which will allow us to more completely assess premature mortality from diabetes.

An attempt has been made to ask only the most relevant questions in order to avoid burdening the cooperating physician with useless and unanalyzable questions. A discussion of the questions follows. Only those which might need further comment are addressed.

Section II

#5. Changes in therapy might indicate a change in the disease and/or an appreciation of complications. A change in therapy (to insulin) may be more difficult for the patient to cope with and thus predispose to hypoglycemia.

#6. Although qualitative in content these questions are quantitative in nature. Data from other studies suggest that the physician's assessment of compliance and control correlates highly with hemoglobin A, an independent assessment of glucose control over several weeks to months.

#7. A gradual increase in the number of office visits and hospital admissions might indicate increasing illness. Likewise, no office visits for a year before a death might indicate under-utilization of medical care.

Section III

#3, 4, 5, 6, 7, and 8. These are standard categories of disease.

#9. Other diseases include body systems not listed in #3 through 8.

#10 and 11. Alcohol and tobacco use are important social variables. The choices given are from those utilized in the Florida Cancer Data System.

Table 2. — Premature Mortality from Diabetes, 1981, Preliminary Summary Statistics from Death Statistics.

Underlying Cause of Death with Any Mention of Diabetes

Cardiovascular	82
Acute Myocardial Infarction	22
Acute Cerebrovascular Accident	8
Congestive Heart Failure	7
Sudden Death (With History of Antecedent Vascular Disease)	45
Diabetes	44
Ketoacidosis	25
Hypoglycemia	3
Renal Failure	16
Sudden Deaths (Without History of Antecedent Vascular Disease)	23
Infections	22
Other	23
Lung Disease	8
Neoplasms	7
Gastrointestinal Disease	4
Other	4
TOTAL	194

PREMATURE MORTALITY STUDY

I. Information on Patient

- 1 Identification
a) Name: _____
Last First M.I.
b) Case number: _____
2. Sex: _____ male _____ female
3. Race
_____ white _____ Asian or Pacific
_____ black _____ Islander
_____ American In- _____ Other
_____ dian or Native _____ Unknown
_____ Alaskan
4. Date of birth: ____/____/____
5. Date of death: ____/____/____
6. County of death: _____
7. County of residence: _____
8. Marital status:
_____ never married _____ divorced
_____ married _____ unknown
_____ widowed
- 9 Occupation:
_____ professional, technical, manager, official, or
_____ proprietor
_____ clerical or sales
_____ craftsman, foreman, operative
_____ service or laborer
_____ homemaker
_____ unknown
10. Place of death:
_____ home _____ emergency room
_____ work _____ hospital (inpatient)
_____ other—specify: _____
11. Certified causes of death:

II. Information on Diabetes and Therapy

1. Type of diabetes: _____ Type I, insulin dependent, ketosis prone, juvenile
_____ Type II, non-insulin dependent, non-ketosis prone, adult
_____ Other (such as, secondary to gestation, pancreatic condition, etc.) Please specify: _____
2. Year of onset 19____
3. How long had you been caring for this patient? _____ years
4. Therapy immediately before onset of terminal illness (check appropriate response): _____ none (skip to Q5)
Diet: prescribed? _____ yes _____ no _____ unknown
if yes, type: _____ followed? _____ yes _____ no _____ unknown
Oral agents: _____ yes _____ no _____ unknown
Insulin: _____ yes _____ no _____ unknown
If yes, patient was on _____ (#) injections per day _____ pump
- Patient self monitoring:
_____ unknown _____ none _____ urine testing
_____ home blood glucose monitoring

5. Had type of treatment changed in past year?
 ____ yes ____ no ____ unknown
 If no or unknown, skip to Q6
 If yes, what was previous treatment? (check appropriate response):
 Diet: prescribed? ____ yes ____ no ____ unknown
 if yes, type: _____
 followed? ____ yes ____ no ____ unknown
 Oral agents: ____ yes ____ no ____ unknown
 Insulin: ____ yes ____ no ____ unknown
 If yes, patient was on _____ (#) injections per day
 ____ pump
 Patient self monitoring:
 ____ unknown ____ none ____ urine testing
 ____ home blood glucose monitoring
6. From the following options:
 1 = excellent, 2 = acceptable, 3 = poor, 4 = very poor
 Please give your overall assessment of patient's:
 last 12 months
 while under your care
- A. Quality of control of diabetes _____
 B. Compliance with diabetic treatment _____
 C. If compliance is less than acceptable, what, in your opinion, is the reason:
 ____ psycho-social ____ clinical ____ access to care
 ____ other reasons (specify) _____
7. Please indicate _____ last 12 months
 while under your care
- A. Number of office visits _____
 B. Number of hospital admissions _____
 C. Estimated total number of hours of diabetes education (by _____
 M.D. & others)
8. To your knowledge, was patient a client of a county health unit? ____ yes ____ no
 If yes, did patient receive state-purchased insulin? ____ yes ____ no
- 9. Information on Complications of Diabetes and General Health**
1. A. Height _____ (inches) B. Weight _____ (pounds)
2. Indicate your assessment of patient's level of physical activity (work & leisure) ____ little or none
 ____ occasional ____ regularly
3. Retinopathy (indicate all appropriate):
 ____ none (skip to Q.4)
 ____ background
 ____ proliferative
 ____ blind (1 or both eyes)*
 ____ cataract (1 or both eyes)*
 ____ unknown
 *Circle appropriate

4. Nephropathy:
record appropriate values (last known)
____ none (skip to Q.5)
Albuminuria ____ Yes ____ no
If yes, duration in years _____
If known, quantity per 24 hrs. _____
____ Creatinine
____ BUN
Recurrent urine infection:
____ yes ____ no
Biopsy of kidney with evidence of
renal disease:
____ yes ____ no ____ not done
Dialysis ____ yes ____ no
Transplant ____ yes ____ no
____ unknown
5. Neurological
(indicate all appropriate):
____ none (skip to Q6)
____ peripheral sensory
____ motor
____ autonomic
____ unknown
6. Vascular (indicate all appropriate):
____ none (skip to Q. 7)
____ angina
____ myocardial infarction
____ CVA
____ intermittent claudication
____ ulceration
____ gangrene
____ unknown
7. Amputation ____ yes ____ no ____ unknown
If yes, extent:
- | | left | right | bilateral |
|------------|-------|-------|-----------|
| toe | _____ | _____ | _____ |
| foot | _____ | _____ | _____ |
| leg | _____ | _____ | _____ |
| below knee | _____ | _____ | _____ |
| above knee | _____ | _____ | _____ |
8. Hypertension ____ yes ____ no ____ unknown
If yes, on therapy: ____ yes ____ no
If yes, was blood pressure control achieved?
____ yes ____ no
9. Other important diseases (check all appropriate):
____ none (skip to Q. 9)
____ Neoplasm
____ Other endocrine
____ disease of blood
____ disease of respiratory system
____ disease of digestive system
____ Gynecologic
____ disease of skin
____ connective tissue
____ mental disorders
____ other (specify): _____

10. Alcohol use: (check most appropriate response):
____ never drank alcohol
____ history of drinking
1 oz. = 1 oz. whiskey or 1 beer or 4 oz. wine
____ light drinker (3 oz. per day)
____ moderate drinker (3-24 oz. per day)
____ heavy drinker (24 oz. per day)
____ unknown

11. Tobacco use (check most appropriate response):
____ never smoked
____ history of smoking
____ less than 1 pack per day
____ 1-2 packs per day
____ more than 2 packs per day
____ smokes cigars
____ smokes a pipe
____ smokes other than tobacco
____ uses snuff or chewing tobacco
____ unknown

IV. Information on Terminal Illness

1. Estimated duration of terminal illness (examples: 3 wks, 2 yrs) _____
2. Was patient in hospital? ____ yes ____ no
If yes, admitting diagnosis(es) _____

3. Operations during terminal illness (list):

4. Was hyperglycemia a factor during terminal illness? ____ yes ____ no
5. Was patient in diabetic coma (ketoacidosis) on admission? ____ yes ____ no
6. Did diabetic coma (ketoacidosis) occur during hospital stay? ____ yes ____ no
7. Was hypoglycemia a factor in terminal illness? ____ yes ____ no
If yes, possible reason(s) (indicate all appropriate):
____ missed meals
____ unusual exercise
____ alcohol
____ excess therapy
____ other-explain _____

8. Was death expected? ____ yes ____ no
Comments: _____

9. Since completing the death certificate, do you have any information that might lead you to alter the causes of death indicated? ____ yes ____ no
If yes, please comment on changes and why: _____

10. Are there lessons to be learned from this case?

STATE OF FLORIDA

Figure 1



Section IV.

#4, 5 and 6. Hyperglycemia and ketoacidosis are important complicating variables which can cause death or complicate any existing problem such as myocardial infarction. These questions will separate the diabetes from the other illnesses.

#7. Hypoglycemia is a rare but clearly potentially fatal complication. A search for reasons is necessary.

It is believed that these questions can be answered very easily by the physician. Indeed, for most of the data, he will not need any records. Death in a relatively young person will be a rare event for the physician and will leave an impression such that most of the details of the case will be at hand.

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1. Turnbridge, W.M.G.: Factors Contributing to Deaths of Diabetics Under Fifty Years of Age, *Lancet*, September 12, 1981.
2. Chamhlee, Ronald T. and Marshall C. Evans: New Dimensions in Cause of Death Statistics, *Am.J.Puh. Health*, Vol. 72, No. 11, 1982.

- Mr. Williams, DHRS, 1317 Winewood Boulevard, Tallahassee 32301.

FLORIDA MEDICAL

DEPARTMENTS

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NOTES & NEWS

Drs. Dockery and Schiebler appointed to AMA panel

Two University of Florida medical faculty members, Dr. J. Lee Dockery and Dr. Gerold Schiebler, have been appointed to a new national review panel commissioned by the American Medical Association to evaluate new technological developments in medical science.

Dr. Dockery is associate dean of UF's College of Medicine and is President-Elect of the Florida Medical Association. He also is a professor of obstetrics and gynecology in the college. At the national level, he is a fellow of the American College of Obstetricians and Gynecologists.

Dr. Schiebler, who has served for 14 years as chairman of the medical college's Department of Pediatrics, is a nationally recognized specialist in pediatric cardiology. He also is active in the FMA, serving on its Board of Governors and was former editor of *The Journal of the Florida Medical Association*. Known for his contributions to scientific literature regarding pediatric cardiology, he has worked extensively at state and national levels to develop and promote legislation aimed at improving the delivery of health care services to children.

The panel to which Drs. Dockery and Schiebler have been appointed is the Diagnostic and Therapeutic Technology Assessment (DATTA) reference panel. Established by the AMA's Council on Scientific Affairs, the DATTA group will provide objective assessment of new diagnostic and therapeutic procedures and techniques, as well as other advanced technologies, in response to inquiries from physicians, health agencies, government and industry, and the public.

The DATTA project is expected to expand the AMA's capability for assessing the relative merits of new and old medical technologies, based on authoritative reference sources.

PIMCO Board of Directors member Bruce Woolery dies at 62

Bruce A. Woolery, a longtime friend of Florida physicians and a member of the PIMCO Board of Directors, died at his home in Palm Desert, California on November 1, 1982. He was 62.

Mr. Woolery sustained a severe coronary occlusion in August 1980 and his sudden death was a direct result of his previous problem. A memorial service for his family and close friends was held in Riverside, California on November 3 and a full military funeral was held on November 4.

As a member of the PIMCO Board of Directors, Mr. Woolery made many contributions to the formation and operation of the Florida Physicians' Insurance Reciprocal. In the first six years of PIMCO's existence, he traveled from California to Florida on a monthly basis to attend Executive Committee and Board meetings. He was also active in negotiations for reinsurance and in the management of the company. His many accomplishments and contributions to Florida medicine were recognized by the House of Delegates of the Florida Medical Association when he received a Certificate of Grateful Recognition in 1981.

Mr. Woolery is survived by his wife, Claire, one son and three daughters.

Dr. William Deal to chair medical council

Dr. William B. Deal, dean of the University of Florida's College of Medicine and UF associate vice president for clinical affairs, is the newly elected chairman of the Southern Council of Medical Deans.

Dr. Deal's election to the council's top administrative position took place at the group's recent fall meeting in Sarasota.

The Southern Council, which includes representation from 49 of the nation's 127 medical colleges, is the largest regional group within the American Association of Medical Colleges' Council of Deans. The medical school administrators who hold membership in the Southern Council represent colleges extending from as far north as Maryland, south to Puerto Rico, and west to Texas.

The Southern Council serves as a forum for deans to discuss mutual problems affecting the medical colleges, such as financial support for students and for research. Members of the council also assist the AAMC in lobbying at the national level for legislation regarding medical care, education and research.

Dr. Deal also serves on the Administrative Board of the AAMC's Council of Deans.

Dr. Franklin B. McKechnie honored by American Society of Anesthesiologists

Dr. Franklin B. McKechnie, Winter Park, has been re-elected Speaker of the House of Delegates of the 18,000 member American Society of Anesthesiologists, it was announced today.

The Winter Park anesthesiologist is former Chief of Staff, Winter Park Memorial Hospital.

Dr. McKechnie has served as President of the Florida Society of Anesthesiologists and is a member of the Executive Committee of the Orange County Medical Society.

A native of Boston, he received the B.S. degree from Harvard in 1942 and M.D. degree in 1945 from Johns Hopkins University, Baltimore. He served his internship at Johns Hopkins and residency in anesthesiology at Indiana University School of Medicine.

Dr. Louis Cimino dies

Louis E. Cimino, M.D., a prominent pediatric cardiologist and a member of *The Journal's* editorial staff, died on October 28. He was 56.

A lifelong resident of Tampa, Dr. Cimino was Director of the Pediatric Cardiology Unit at All Children's Hospital in St. Petersburg. He was a graduate of St. Louis University Medical School.

Dr. Cimino was a Past President of the Hillsborough County Medical Association. At the time of his death, he was Editor of the *Hillsborough County Medical Association Bulletin* and a consulting editor of *The Journal of the Florida Medical Association*.



DEAN'S MESSAGE

A Dean's observations of the fall meeting of the FMA Board of Governors

Each year the Florida Medical Association invites the Deans of the three Florida medical schools to attend its Annual Board of Governors meeting. The University of Miami School of Medicine has always been represented by the Dean or his designee. This is the first time that I have had an opportunity to attend and to participate in the business meetings and social events of the association. The experience turned out to be more than just informative for me as a physician.

It reinforced my own conviction that the complex issues facing the medical profession are very similar both for the practicing clinician and for the physician who practices within an academic health center.

Early in the deliberations, Dr. William Deal, Dean of the University of Florida College of Medicine, and I were given the opportunity to present the respective status reports of our schools. Both of us reported that despite the tremendous constraints being placed on our institutions by the federal government (i.e., loss of flexible institutional educational funds, reduction in federal support for biomedical research, and cost reimbursement provisos that could have greater impact on academic health centers than the individual physician) our medical schools were doing well and should be a source of pride to the over 20,000 practicing physicians in the state.

Dr. Deal pointed out the problems created by American students studying in foreign medical schools and their attempt to obtain clinical education in Florida hospitals, particularly South Florida. Aspects of this topic were well covered in Dr. Richard Feinstein's fine article in the October issue of the *Journal* (Vol. 69, No. 10). This is a national problem. However, New York, California and Florida are particularly hard hit by the pressures to provide clinical opportunities for the students studying abroad. With the proliferation of medical schools in the Caribbean, the University of Miami School of Medicine has been deluged with requests to train junior and senior students either through eighth semester electives, a fifth pathway, or more frequently, the full clerkship program. Our faculty unanimously voted to prohibit American students studying abroad from taking clinical training in the University of Miami-Jackson Memorial Center. We are indeed sympathetic to the needs of these students. However, it is unfair to our own students to have their training resources at our hospitals diluted by crowding the existent facilities. This decision is not popular, but we feel that it is correct. Finally, there is the additional factor of the potential liability posed by non-matriculated students. To the best of my knowledge, most other hospitals in South Florida have adopted similar policies. Recently, one Caribbean school advertised that it has made affiliation agreements with at least three hospitals located in Dade County. It is my view that for the hospitals to provide this type of training is a mistake. The students simply cannot be given an adequate education: faculty are unavailable to supervise their activities; the students will be used as operating room assistants and to do scut work, not a quality educational experience. Most importantly, the hospitals have not considered the professional liability aspect of their decision. Clearly, they could be liable for any incidents involving these clinical clerks.

The Board also devoted a substantial amount of time to discussing the professional liability crisis

confronting physicians in Florida. I found it gratifying to participate and contribute insights based on the experiences of a large medical center. Moreover, the actions taken by the Board reflected an understanding and concern for the needs of all patients receiving medical services (public and private) and not simply those taken care of in the traditional setting. I was particularly pleased that the primary objectives of the reforms suggested to deal with the professional liability issue were directed at eliminating defensive medicine, improving health care delivery, and dealing realistically with major cost containment issues created in part by the "crisis".

Unfortunately not enough attention, in my opinion, is being paid to the problem of differentiating between a poor outcome (unrelated to medical incompetence but a result of the injuries or events that led to the patient's being seen by a physician) and medical negligence. This is an issue that I would like to address in broader terms in subsequent issues of *The Journal of the Florida Medical Association*.

I will not attempt to provide a recap of all the items relevant to training institutions. I do, however, believe that most of the major topics that will impact on the type of health care delivery provided in this country were considered at the meeting. In each instance, the deliberations were constructive and characterized by a genuine desire to provide the best health care possible. For my first, and certainly not my last, Board meeting it was an extremely fine experience, and I am most grateful to the President, Dr. Robert Windom, and the Board for including the University of Miami School of Medicine in this activity.

Bernard J. Fogel, M.D.
Vice President for Medical Affairs
and Dean, University of Miami
School of Medicine

At least this sort of finding gives some concrete negative effect that can be reported to patients to dissuade them from the magical nonsense that they so dearly love.

N. Henry Pevsner, M.D.
Lake Worth



WORTH REPEATING

United we stand

United we stand. Divided we fall. How often through the years have we heard that phrase? It's as American as baseball and apple pie. It's one of those phrases with which nearly everyone agrees without giving it a second thought. It just sounds right. Yet every once in a while physicians substitute divide and conquer for united we stand.

The recent problem with the Patient's Compensation Fund found the Florida Medical Association at odds with a group of physicians in Dade and Broward counties. This group believed that the FMA was not moving fast enough to help them through the crisis and decided to take some action on their own. Now instead of one strong voice we have two groups of doctors trying to accomplish the same thing, each in their own way.

What bothers me most about this situation is that most of our colleagues are reluctant to get involved in anything, let alone having different groups vying for their support. The same people now willing to support a new group with a fancy name are the same ones who shunned involvement in organized medicine over the years. All of a sudden they arrive on the scene, denounce the FMA as a do-nothing organization, and willingly give money to a new organization. I wonder how many are FLAMPAC members? Probably not many, but they are willing to support a group that promises change.

I was always taught if you don't like how things are done, get involved and work for change from within. The present squabble reminds me of a child who doesn't like how the game is played so he takes his ball and goes home.

In all fairness, both groups were able to help obtain at least a temporary solution for the P.C.F. What we need now, however, is unity so we can work together for a total solution of the professional liability problem. We will need everyone's support this year. Just getting doctors to help will be hard enough. The last thing Florida physicians need is competing organizations bickering among themselves and going their own way.

Lee A. Fischer, M.D.
West Palm Beach

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CORRESPONDENCE

Editor's Note: Dr. Harrell's article "What do you tell a dieter" was reprinted from the *Bulletin of the Marion County Medical Society*, November 1981.

To the Editor: I read Dr. Henry Harrell's reprinted comment on page 803 of September JFMA (Vol. 69, No. 9). I want you to relate to him and to your other readers if you find it appropriate, my findings in this regard several years ago.

I wrote to the AMA drug division that I'd had two patients that had utilized HCG. Both of these patients experienced elevation of their platelet count. One of the patients in order to prove my point, was withdrawn from the HCG and her platelet count fell to normal and then when she restarted HCG shots, the platelet count again rose.



Book Review Editor — **F. Norman Vickers, M.D.**

The hour of our death

By Philippe Aries, 651 Pages. Price \$20.00. Alfred Knopf, New York, 1981.

Physicians have developed an increasing ability to prolong life and to prolong the act of dying. Because of this we have the need to make decisions regarding life and its continuation. We therefore need a solid perspective of the ethical, moral, religious and psychological implications of death to the individual.

Philippe Aries' book is then an important contribution to the literature on death and dying. He views our attitudes on death in their historic perspective. He traces a series of changes that have occurred in our attitude toward death starting with our old attitudes with their roots in the Greco-Roman world. About 1000 A.D. these attitudes began to change, beginning with the "tame death" in which death is familiar and not frightening, and in which each life is secondary to the community. Following this there developed an awareness of each individual person and his relation to the afterlife.

Later in the 16th and 17th centuries, attention swung from the death of the individual to the deaths of other persons, such as children and spouse, that make the problem of separation a difficult one. Finally, in our time, death has been banished from our lives to form an "invisible death."

In modern times, the denial of death takes many forms. The individual will be treated as someone with an illness rather than someone dying. The person will be taken from his home and family to be in a hospital. Mourning is suppressed. The body is dressed as though still alive. There is an illusion of the continuation of this life and very little allusion to afterlife.

Mr. Aries' research stems from an analysis of the literature written at that time, from a study of documents such as wills, etc., as well as from an analysis of grave stones, churchyards and church inscriptions.

The majority of the sources are European, particularly French. He does include some analysis of American data as well, but the primary sources are French and Catholic. To the extent that we share a common heritage with Western Europe this is quite appropriate. Some comment is made to the extent to which American and English attitudes differ. Occasional Latin phrases occur which may be beyond the reader who has not passed Latin I, but this is only a minor problem.

This book is somewhat detailed and monumental in its scope. I would recommend it for those physicians who deal with dying patients. An interesting accompanying book might be Dr. Kubler-Ross' book *On Death and Dying*.

Stanley S. Goodman, M.D.

- Dr. Goodman is a practicing cardiologist in Fort Lauderdale.

Handbook of heart terms

By The National Heart, Lung & Blood Institute, Price \$4.95. Enslow Publishers, Hillside, New Jersey, 1982.

Originally issued by the National Institute of Health, *Handbook of Heart Terms* is now available in hardcover from Enslow Publishers. This illustrated handbook is a quick reference guide for anyone who wants to understand the human heart, how it functions, and what can go wrong. Over 400 heart-related terms are defined in language that is clear and non-technical. The terms are in alphabetical order, most are followed by pronunciation aids, and many are illustrated.

The *Handbook* is intended for patients and their families, educators, and health care professionals.

Happy holidays, dear doctor

Just about now holiday cards are pouring into your office and piling up on the coffee table at home. Each greeting is important to you because it represents time, effort, and caring on the part of the sender. You would like to have the luxury of time enough to sit down, relax, examine every card carefully, and savor the nuances of each verse. Unfortunately, after long days of surgery and office hours, you are usually limited to a few minutes to glance at the colorful picture on the outside of the card and the signature inside. Your life is hurried and even time for enjoying signs of affection and appreciation is at a premium.

Please, slow down for a minute to read this special holiday greeting from your Auxiliary and your spouse. Better than anyone else we

know your dedication to duty and the many sacrifices you make to give the best possible care to each patient. You are a very special person, devoting most of your waking hours to helping others. You seldom complain about missing nights of much needed sleep, eating warmed over dinners (or missing dinner completely), being called back to work in the middle of family parties, not seeing the excited faces of your children as they open birthday presents, or cancelling a long-awaited fishing trip in favor of a "hot" appendix. That oath you took some years ago is the guiding light of your life and you are faithful in preserving its integrity.

This life of sacrifice has become so habitual that you rarely think of the hard work and long hours — but other do. In their names let us say:

*May this holiday season
bring you the peace, happiness
and fulfillment
you so richly deserve*

The Florida Medical Association Auxiliary

AMA-ERF fund raiser

You may contribute to the American Medical Association Education and Research Foundation by purchasing Medical Motif T-shirts.

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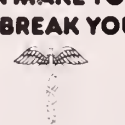
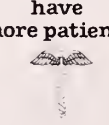


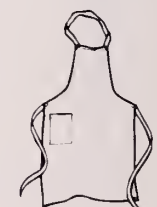
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"OPHTHALMOLOGISTS MAKE YOU SEE THE LIGHT."  7	"PLASTIC SURGEONS MAKE MOUNTAINS OUT OF MOLEHILLS."  8	"Obstetricians deliver the goods."  9	"Surgeons are clever cutups."  10	"Trust your heart to a CARDIOLOGIST."  11	"BABY DOCTORS NEED A CHANGE."  12
"Tell your PROCTOLOGIST to sit on it."  13	"DERMATOLOGISTS make rash decisions."  14	"NEUROLOGISTS get on my nerves."  15	"PATHOLOGISTS are dead serious."  16	"Internists know you from the inside out."  17	"SLEEP BETTER WITH AN ANESTHESIOLOGIST."  18
"Have you hugged your doctor today?"  19	"ORTHOPEDISTS CAN MAKE YOU OR BREAK YOU."  20	"Family physicians have more patience."  21	"Radiologists see right through you."  22	 Tote 23	 Apron 24



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Each fluid ounce contains: Codeine Phosphate 65.8 mg • (WARNING: MAY BE HABIT FORMING) Phenylephrine Hydrochloride 30 mg • Phenylpropanolamine Hydrochloride 20 mg • Pheniramine Maleate 20 mg • Pyrilamine Maleate 20 mg • Ammonium Chloride 200 mg • Alcohol 5%

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RU-TUSS[®]

Tablets

DESCRIPTION

Each prolonged action tablet contains

Phenylephrine Hydrochloride	25 mg
Phenylpropanolamine Hydrochloride	50 mg
Chlorpheniramine Maleate	8 mg
Hyoscyamine Sulfate	0.19 mg
Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours

Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings).

OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.

ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.

HOW SUPPLIED:

Bottles of 100 Tablets
Bottles of 500 Tablets

NDC 0524-0058-01
NDC 0524-0058-05

Federal law prohibits dispensing without prescription.

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MANUFACTURED BY:

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RU-TUSS[®]

Expectorant

DESCRIPTION

Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate	65.8 mg
(WARNING: MAY BE HABIT FORMING)	
Phenylephrine Hydrochloride	30 mg
Phenylpropanolamine Hydrochloride	20 mg
Pheniramine Maleate	20 mg
Pyriminamine Maleate	20 mg
Ammonium Chloride	200 mg
Alcohol	5%

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and expectorant preparation.

INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of upper respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rhinitis. Also, for the temporary relief of symptoms associated with hay fever, allergies, nasal congestion and cough due to the common cold.

CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an anti-hypertensive or antidepressant drug containing a monoamine oxidase inhibitor is contraindicated.

Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma and in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient should be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effect caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle or operating dangerous machinery (See Warnings). Caution should be taken with patients having hypertension, diabetes, hyperthyroidism and cardiovascular disease.

Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddiness, dryness of mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, and insomnia. Overdoses may cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and even convulsions.

DOSAGE AND ADMINISTRATION Adults, 1 or 2 teaspoonfuls, orally, every 4 hours, not to exceed 10 teaspoonfuls in any 24-hour period.

Children 6 to 12 years of age: $\frac{1}{2}$ the adult dose, not to exceed 6 teaspoonfuls in any 24-hour period. Children 2 to 6 years of age: $\frac{1}{2}$ teaspoonful every 4 hours, not to exceed 3 teaspoonfuls in any 24-hour period. Children under 2 years of age: Use as directed by a physician.

HOW SUPPLIED: (16 fl. oz.)

Pint Bottles

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The FMA-sponsored Retired Lives Reserve is restricted to member physicians and their staffs.

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A medical examination is not required for eligibility.

Get the facts.

Space does not permit all of the outstanding benefits of the Wraparound Retired Lives Reserve program to be listed here. The FMA and MAPS urge you to acquaint yourself with the numerous benefits of this customized Retired Lives Reserve program. Mail the attached postcard to arrange a confidential appointment with a MAPS representative to see what this innovative plan can mean to you.

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Meetings

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JANUARY 1983

Medical Sociology, Jan. 6, Holy Cross Hospital, Ft. Lauderdale. For information: Jon Fichtelman, M.D., P. O. Box 23460, Fort Lauderdale 33307, (305) 771-8000 Ext. 5728.

28th Annual Cardiovascular Seminar, Jan. 7-8, Dolphin Beach Resort, St. Petersburg Beach. For information: Mr. E. Jerry Eatman, P.O. Box 7188, St. Petersburg 33734.

Primary Care of the Aged Patient, Jan. 8, Airport Hilton Hotel, Tampa. For information: Richard Ham, M.D., 1740 West 92nd Street, Kansas City, MO 64114.

Pharmacology of Hypertension, Jan. 10, St. Mary's Hospital, W. Palm Beach. For information: Gerald J. O'Connor, M.D., St. Mary's Hospital, 901 45th Street, W. Palm Beach, FL 33407, (305) 659-1633.

6th Annual Review in Oral Pathology, Jan. 10-14, University of Miami, Miami. For information: University of Miami CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

Grand Prix Road Racing — Medical Aspects, Jan. 12, Peace River Country Club, Bartow. For information: Mrs. Elsie Trask, Exec. Dir., Polk County Medical Society, (813) 682-0543.

Coexistent Pulmonary and Cardiac Disease, Jan. 12, Mount Sinai Medical Center, Miami. For information: Marvin L. Meitus, M.D. and Adam Wanner, M.D., 4300 Alton Road, Miami Beach 33140, (305) 674-2311.

2nd International Advanced Arthroscopic Update, Jan. 12-15, Sand Piper Bay, Port St. Lucie. For information: Ronald Grober, M.D., 2000 Nebraska Ave., Ft. Pierce, FL 33450. (305) 464-3657.

Youth and Hypertension: The Challenge for Today, Jan. 13, Brickell Point Holiday Inn, Miami. For information: G. L. Sanders, M.D., (305) 757-0113/547-6593.

The Second Biennial Palm Beach Aesthetic Surgery Symposium, Jan. 13-16, The Breakers, West Palm Beach. For information: Douglas D. Dedo, M.D., 1515 N. Flagler Dr., West Palm Beach, FL 33401. (305) 659-2266.

8th Annual Review & Recent Practical Advances in Pathology, Jan. 17-21, University of Miami, Miami Beach. For information: Univ. of Miami School of Medicine, Dept. of Pathology, P.O. Box 016960, Miami 33101, (305) 325-6437.

Calcium Blockers for the Treatment of Angina Pectoris, Jan. 18, Holy Cross Hospital, Ft. Lauderdale. For information: Jon R. Fichtelman, M.D., P.O. Box 23460, Ft. Lauderdale 33307, (305) 771-8000, Ext. 5828.

15th Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 19, Sheraton Bal Harbor Hotel, Miami Beach. For information: Victor Politano, M.D., 6614 Miami Lakes Drive East, Miami Lakes 33014, (305) 687-1367.

Fifth Annual Walt Disney World Pulmonary Wintercourse, Jan. 20-23, Hotel Royal Plaza, Lake Buena Vista. For information: Milton Braunstein, M.D., 5526 Arlington Road, Jacksonville 32211. (904) 743-2933.

Acute Spinal Cord Injury — Comprehensive Management, Jan. 20-23, Sheraton Bal Harbour Bal Harbour. For information: CME, University of Miami School of Medicine, P.O. Box 016960, Miami 33101. (305) 547-6716.

Continuing Education in Pediatrics - 1983, Jan. 23-27, Diplomat Hotel, Hollywood. For information: Donald H. Altman, M.D., 6125 Southwest 31st Steet, Miami 33156, (305) 667-7060.

Twenty-First Annual Seminar "What's New in Diagnostic Imaging and Interventional Techniques", Jan. 23-28, Sheraton Bal Harbour, Bal Harbour. For information: Lucy R. Kelley, Radiology Seminars, Inc., P. O. Box 343762, Coral Gables 33134.

Advances in Orthopedics — 1983, Jan. 26-28, Holiday Inn Surfside, Clearwater Beach. For information: Deborah Smelt, USF, Box 36, Tampa 33612.

2nd Annual Contemporary Nutrition Practice Seminar, Jan. 28, University of South Florida, Tampa. For information: P. Oelslager, R.D., Nutrition Services, Davis Island, Tampa 33606. (813) 253-0711.

Round Table Day, Jan. 28, Diplomat Resorts, Hollywood. For information: D.H. Altman, M.D., 6125 Southwest 31st St., Miami 33156, (305) 667-7060.

Clinical Management of Coronary Disease and Dual Mode Exercise Testing, Jan. 28-30, Hilton Gateway, Orlando. For information: Stephen Mattingly, 64 Inverness Dr., E., Englewood, Colorado 80112. (800) 525-8651.

Symposium on Intensive Care, Jan. 29 - Feb. 5, Vail, Colorado. For information: University of Miami School of Medicine, P.O. Box 016960, Miami 33101, (305) 325-6726.

The 10th Annual Symposium in Pediatric Nephrology; Current Concepts in Diagnosis and Management, Jan. 30 - Feb. 3, University of Miami, Miami. For information: Univ. of Miami School of Medicine, Department of Pediatrics, P.O. Box 016960, Miami 33101, (305) 325-6726.

FEBRUARY

The Seventeenth Annual Symposium on Cosmetic Surgery, February 3-5, Cedars Medical Center, Miami. For info.: Thomas J. Baker, M.D., 1501 S. Miami Ave., Miami 33129. (305) 854-2424.

Clinical Approach to Exercise Testing, Feb. 3-5, Hyatt Orlando, Orlando. For info.: Stephen P. Glasser, M.D., Univ. of South Florida College of Medicine, Box 19, 12901 N. 30th Street, Tampa 33612, (813) 974-2880.

Adult & Pediatric Urological Cancers, Feb. 4-5, St. Joseph's Hospital, Tampa. For information: Bruce Collison, Community Relations (813) 870-4340.

The Seventeenth Annual Symposium on Cosmetic Surgery, Feb. 3-5, Cedars Medical Center, Miami. For information: Thelma McGregor, 1400 N.W. 12th Ave., Miami. (305) 325-5558.

Family Practice Weekend, February 4-6, The Hilton Hotel, Gainesville. For information: William Lassiter, M.D., 625 S.W. Fourth Ave., Gainesville. (904) 392-4541.

10th Annual George F. Paff Seminar, Feb. 4-6 Ft. Lauderdale. For information: Univ. of Miami, Division of Continuing Medical Education, P.O. Box 016960, Miami 33101, (305) 547-6716.

Third Annual Treasure Coast Medical-Surgical Review, Feb. 5-6, Dodgertown Conference Center, Vero Beach. For information: John L. Rodgers, M.D., P.O. Box 573, Vero Beach 32960, (305) 567-9711.

The Postgraduate Seminar in the Fundamentals of Otolaryngic Allergy and Clinical Applications, Feb. 5-10, Don CeSar Beach Resort, St. Petersburg Beach. For information: Hueston C. King, M.D., 4675 Ponce DeLeon Blvd., Miami 33146.

9th Annual Conference on Anesthesiology, Feb. 5-12, Vail, Colorado. For information: Univ. of Miami School of Medicine, Dept. of Anesthesiology (R370), P.O. Box 016960, Miami 33101, (305) 547-6411.

Internal Medicine 1983 — 18th Annual Postgraduate, Feb. 6 - 11, Miami Beach. For info.: Univ. of Miami School of Medicine.

P.O. Box 016960, Miami 33101, (305) 547-6063.

Topics in Geriatric Medicine, Feb. 10-12, Diplomat Resort and Country Club, Hollywood. For information: Kevin Newman, M.D., (305) 841-5144.

Prostaglandins in Medicine, Feb. 11-12, The Dutch Inn, Lake Buena Vista. For information: Ms. Grace Wagner, University of Florida, Box J-233, JHMH, Gainesville 32610, (904) 392-3143 or 392-3183.

10th Annual Homecoming Symposium, Feb. 11-12, Sonesta Beach Hotel, Key Biscayne. For information: University of Miami School of Medicine, Department of Psychiatry (D29), Post Office Box 016960, Miami 33101, (305) 325-6335.

Florida Midwinter Seminar in Ophthalmology, Feb. 14-16, West Palm Beach. For info.: University of Miami School of Medicine, Department of Ophthalmology (D880), P.O. Box 016960, Miami 33101, (305) 547-6540.

Florida Midwinter Seminar in Otolaryngology, Feb. 17-19, West Palm Beach. For information: University of Miami School of Medicine, Department of Ophthalmology (D880), P. O. Box 016960, Miami 33101, (305) 547-6540.

Clinical Management of the Elderly Patient for the Practicing Physician & Other Health Professionals, Feb. 18-19, Americana Dutch Inn, Orlando. For information: L. Gregory Pawlson, M.D., M.P.H., Rm. 322, 1229 25th St., N.W., Washington, D.C. 20037.

The 7th Annual Symposium in Clinical Cardiology, "Cardiovascular Pharmacology", Feb. 18-19, Sheraton Sand Key Hotel, Clearwater. For info.: Donald R. Eubanks, M.D., Morton F. Plant Hospital, 323 Jeffords Street, Clearwater 33517, (813) 441-5166.

Arrhythmias & Cardiac Ischemia: Diagnosis & Management, Feb. 18-20, Bahia Mar

Hotel, Ft. Lauderdale. For information: International Medical Education Corp, 64 Inverness Dr. E., Englewood, Colorado 80112, (800) 525-8651.

The 4th International Workshop on Neurological Surgery of the Ear and Skull Base, Feb. 19-24, Hyatt House, Sarasota. For Information: Marcia Gordon, Sarasote County Medical Society, 1845 Hillview Street, Sarasota 33579, (813) 366-2700.

International Radiology Conference, Feb. 20-Mar. 6, Tokyo-Hong Kong-Honolulu. For information: Lucy R. Kelley, Radiology Seminars, Inc., P.O. Box 343762, Coral Gables 33134.

Conference on the Beach - 4th Annual Family Practice Update, Feb. 21-26, Daytona Hilton, Daytona Beach. For information: Richard W. Dodd, M.D., (904) 258-1584.

Hepatobiliary Disease in Clinical Practice V, Feb. 24-26, Sheraton Bal Harbour, Bal Harbour. For information: University of Miami School of Medicine, Department of Continuing Medical Education (D23-3), P.O. Box 016960, Miami 33101, (305) 547-6716.

10th Pediatric Dermatology Seminar, Feb. 24-27, Carillon Beach Hotel, Miami Beach. For information: Guinter Kahn, M.D., Parkway Hospital Medical Plaza, Suite 401, 16800 N.W. 2nd Ave., North Miami Beach 33169, (305) 652-8600.

Peripheral Vascular Disease for the Non-Surgeon, Feb. 25, Royal Palm Yacht Club, Fort Myers. For information: Warren E. Hagen, M.D., 3596 Broadway, Fort Myers 33901, (813) 936-8555.

Eighth Annual Midwinter Seminar in Obstetric and Gynecology, Feb. 25-27, Don Cesar Beach Resort Hotel, St. Petersburg. For information: Dept. of OB/GYN, Medical Center, Box 18, Univ. of S. FL, Tampa 33612. (813) 974-2088.

Spine Surgery, Back to Basics, Feb. 28-March 3, Kissimmee.

For information: Univ. of Miami School of Medicine, Department of Orthopedics (D27), P.O. Box 016960, Miami 33101, (305) 547-6996.

Basic Neurology for Psychiatrists and Generalists, Feb. 27-March 4, Miami Beach. For information: University of Miami School of Medicine, Department of CME, Post Office Box 016960, Miami 33101, (305) 547-6716.

MARCH

15th Teaching Conference in Clinical Cardiology, Mar. 2-5, The Sheraton Bal Harbor Hotel, Bal Harbor. For information: Michael Gordon, M.D., University of Miami School of Medicine, Medical Training & Stimulation Lab., P.O. Box 016960, Miami 33101, (305) 547-6491.

Breast Disease Update, Mar. 2-6, Dutch Inn, Lake Buena Vista. For information: Lourdes S. Fuentes, Mount Sinai Medical Center, 4300 Alton Road, Miami 33140, (305) 674-2424.

Intensive Care for Neurological Trauma and Disease 1983, March 2-6, Americana Dutch Resort Hotel, Lake Buena Vista. For information: Division of CME D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami 33101. (305) 547-6716.

Current Topics in Internal Medicine, March 3-5, PGA Sheraton Resort, Palm Beach Gardens. For info.: Michael C. Schweitz, M.D., (305) 659-4242.

Internal Medicine Update '83, Mar. 7-12, Americana Dutch Resort Hotel, Lake Buena Vista. For information: Barry E. Sieger, M.D., 1414 South Kuhl Avenue, Orlando 32806, (305) 841-5144.

Hematology-Oncology Update, Mar. 8-11, Holiday Inn Surfside, Clearwater. For information: Robert Miller, M.D., 701 6th St. S., St. Petersburg 33701, (813) 823-1234, Ext. 2022.

1st Annual Gulfcoast Hematology/Oncology Conference Mar. 9-11, Holiday Inn, Surfside, Clearwater. For information: Robert Miller, M.D., (813) 823-1234, Ext. 2022.

Fourth Annual Pediatric Neurology Postgraduate Course, Mar. 9-12, Eden Roc Hotel, Miami Beach. For information: Michael Duchowny, M.D., 6125 S.W. 31st St., Miami 33155, (305) 666-6511.

Problems in Rheumatology, Mar. 10-13, Don CeSar Beach Resort Hotel, St. Petersburg. For information: Bernard Germain, M.D., Univ. of South Florida, Box 19, 12901 North 30th Street, Tampa 33612, (813) 974-2681.

E C G Interpretation of Arrhythmia Management, Mar. 11-13, Sheraton Royal Biscayne, Key Biscayne. For information: Stephen E. Mattingly, 64 Inverness Dr., E., Englewood, Colo. 80112. (800) 525-8651.

Fifth Annual Winter Seminar of the Miami Ophthalmological Society, Mar. 12-19, Sun Valley Lodge, Sun Valley, Idaho. For information: David J. Singer, M.D., F.A.C.S., 1160 Kane Concourse, Miami Bch. 33154, (305) 861-4946.

14th Annual Topics in Internal Medicine, Mar. 17-18, Gainesville Hilton, Gainesville. For information: Ms. Grace Wagner, University of Florida CME, JHMH, Box J-233, Gainesville 32610, (904) 392-3143 or 392-3183.

Colposcopy and Laser in Gynecologic Practice - Update 1983, Mar. 17-19, Holiday Inn Surfside, Clearwater Bch. For information: Department of OB/GYN, Medical Center, Box 18, Univ. of S. FL, Tampa 33612. (813) 974-2088.

Ambulatory Electrocardiology: Clinical Applications, Methodology and Interpretation, Mar. 18-20, Don CeSar Hotel, St. Petersburg. For info.: Stephen E. Mattingly, 64 Inverness Dr., E., Englewood, Colo. 80112. (800) 525-8651.

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Chicago, Illinois

Edmund H. Sonnenblick, M.D.
Professor of Medicine
Albert Einstein College of Medicine
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HIGHLIGHTS

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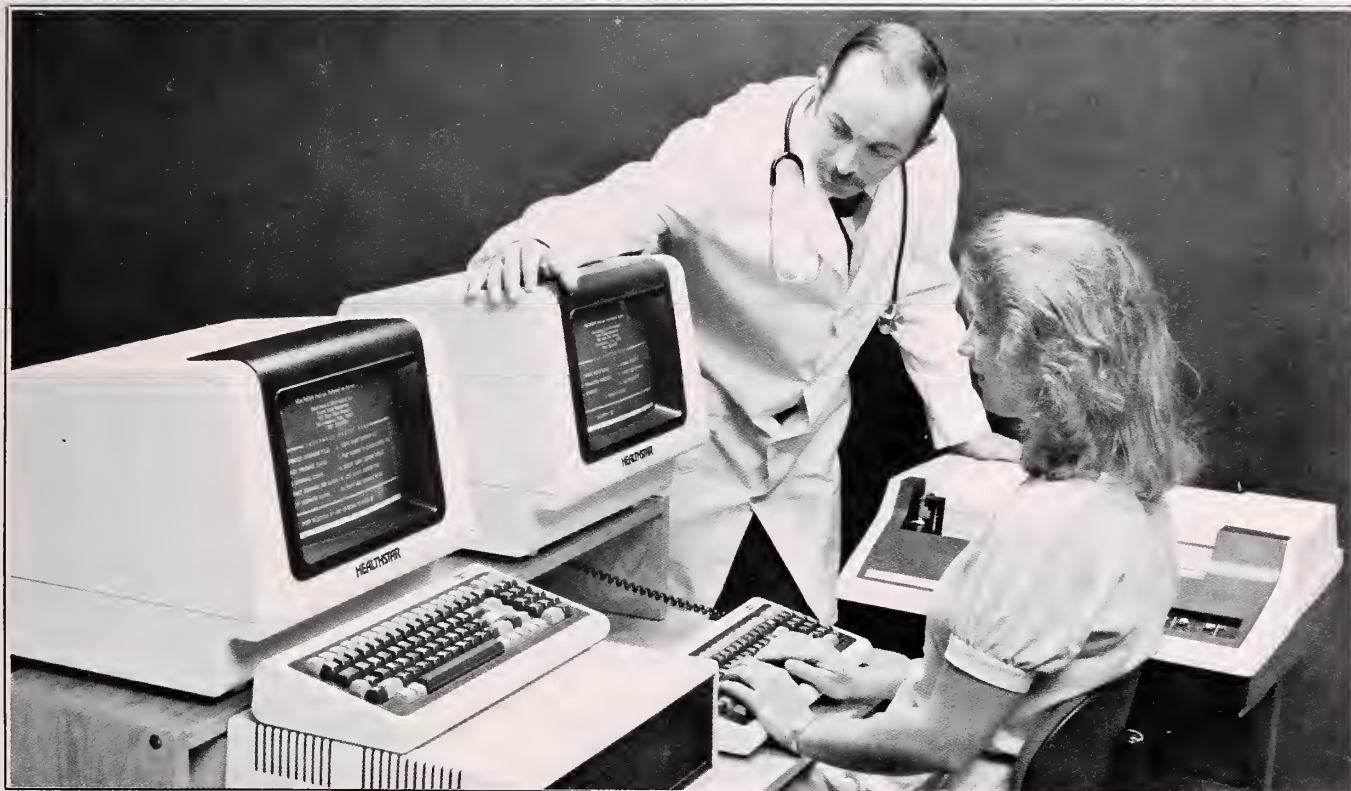
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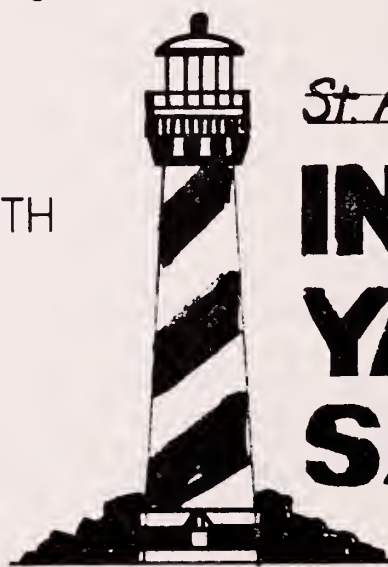
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